

Experiences of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003: A Discourse Analysis

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ATTESTATION OF AUTHORSHIP

“I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.”

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ABSTRACT

The Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (IDCCRA) was passed in order to better meet the care and rehabilitative needs of intellectually disabled offenders. This legislation represents a unique departure from legislative processes utilised in comparable jurisdictions internationally for this group with the development of an alternative pathway for intellectually disabled offenders.

This research explored the experiences of individuals who have become subject to the IDCCRA as described by the ‘care recipients’ themselves and people who were involved in supporting them. A social constructionist methodology was utilised to identify discourses deployed by individuals subject to the IDCCRA both prior to and following release. The research asked the specific question, ‘What are the discourses that come into play prior to and upon release from the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 and how do these discourses construct individuals who become subject to the Act?’ A particular research goal was to identify both dominant discourse and counter discourses within the IDCCRA framework that provided alternative constructions for care recipients.

Findings indicate that the dominance of intellectual disability and criminal discourses had a significant impact on the social construction of care recipients as permanently impaired, criminal, vulnerable and risky. I argue that the intellectual disability and criminal discourses have the effect of limiting rehabilitation and the potential for community integration provided under the framework. The research poses that the deployment of a capable person discourse as a counter discourse allows for alternative constructions of care recipients to emerge, such as capable and having potential to change behaviour and become contributing community members. A capable person discourse allows for the implementation of rehabilitation to occur with a focus on learning and improvement.

Finally, the research poses that consideration of care recipients as both offenders and intellectually disabled individuals must occur within the philosophical imperatives of rights protection and community participation for the broader group of intellectually disabled people in New Zealand. Rights protection and community participation are key goals of the United Nations Convention on the Rights of Persons with Disabilities, of which New Zealand is a signatory, and the New Zealand Disability Strategy. It is essential that the provision of compulsory care and rehabilitation to care recipients is considered within the philosophical imperatives espoused in these documents.

CHAPTER 1 – INTRODUCTION

Introduction

Intellectually disabled people have been overrepresented in the criminal justice system for many years in various Western jurisdictions (Hayes, 2007a). Intellectually disabled offenders are considered to be disadvantaged by a legal process they do not understand and communication difficulties they experience at all stages of the criminal justice process (Hayes, 2000a). They are also considered highly vulnerable in a prison environment that is unlikely to meet their disability support needs and in which they are likely to be victimised by others (Hayes, Shackell, Mottram, & Lancaster, 2007).

Historically, intellectually disabled people engaging in offending behaviour were managed both through the use of the Mental Health Act 1969 (MHA) and placement in large institutions (Milner, 2008). Following reform to mental health legislation in 1992, a legislative gap was created for intellectually disabled people who were no longer able to be placed under the MHA on the basis of having an intellectual disability (Duncan, 2013). The reform resulted in a number of perceived ‘risky’ individuals being released into the community, prompting significant public safety concerns (Brookbanks, 2003).

The Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (IDCCRA) was an attempt to both address the legislative gap and provide an appropriate alternative to prison for intellectually disabled offenders. The Bill passed its final reading on the 21st October 2003 and came into force on 1st September 2004. The IDCCRA had the specific purpose of providing “courts with appropriate compulsory care and rehabilitation options for people who have an intellectual disability and are charged with, or convicted of,

an imprisonable offence” (O’Connor, 2003, p. 9558). In addition, the IDCCRA has a purpose relating to protecting the rights of individuals who became subject to the Act.

The IDCCRA reflects the belief that the needs of individuals with an intellectual disability are different to those with a mental health diagnosis and therefore a distinct legislative track that caters for them is justified (Brookbanks, 2003). They are defined as having different needs and requiring a separate and unique pathway to that provided for other criminal offenders. Ostensibly, the Act has an underlying philosophy of ensuring the least restrictive environment for individuals receiving compulsory care. This requires that care recipients subject to the IDCCRA move through a continuum of service provision which accords increasing levels of freedom (Taylor, 1988).

Concerns have been raised by a number of groups over the last twenty years about the risk of IDCCRA breaching the rights of care recipients as intellectually disabled individuals. One concern related to the separation of this group from mainstream offenders on the basis of a normalisation argument that intellectually disabled offenders should be treated in the same manner as other offenders (Duff & Sakdalan, 2007). Other concerns related to the ability to extend compulsory care beyond the original term made by the court. These concerns were raised during the Health Select Committee review, in the Parliamentary Debates and in various reports commissioned by the government to inform policy development. They have also been raised in several publications both prior to and following the passing of the IDCCRA. These will all be described in detail in Chapters Two and Three.

Purpose

The purpose of the study was to provide a unique examination of the experiences of people who had become subject to the IDCCRA; that is, both the offender identified as

having an intellectual disability and the service providers who provide care and support. The IDCCRA represents a departure from other Western jurisdictions in the treatment and management of intellectually disabled offenders. The fact that it is a unique piece of legislation makes it of interest. There was a significant need to conduct research on the IDCCRA to explore whether the stated intention of the IDCCRA, to provide a better alternative to prison for intellectually disabled offenders and to protect the rights of the individuals subject to the IDCCRA, was being met. Various authors, such as Brookbanks (2003, 2013), Prebble et al. (2013) and Diesfeld (2013), have asserted that lack of attention to this group and this unique legislation could lead to further marginalisation and breaches of rights for this group.

Locating myself in the study

In 2003 I decided to take a job working in disability as a care manager, which was a new area of work for me. As a social worker I had always been interested in social justice issues and had most recently worked in the area of mental health. At that point I had no idea the significance of that decision or the passion I would develop for the area as a result. I immediately developed an interest in the lives of disabled people and a commitment to the improvement of their social position in the community.

The job involved working under what was called the High and Complex Framework, a framework of supports that had been set up in anticipation of a new legislation called the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, which was not yet enacted. At that stage I worked with a number of intellectually disabled offenders who were going through the criminal justice system in the absence of the new legislation. This provided a unique comparator in terms of how the criminal justice system dealt with this group prior to the IDCCRA being in place. What I observed was a level of disadvantage in

terms of the intellectually disabled person's diminished ability to understand the legal system and the potential consequences of their offending behaviour. I observed a lack of specialist skills on the part of court staff dealing with this group. I also observed a lack of specialist skills in terms of the support provided to them in the residential service.

On the 2nd September 2004 I had the very dubious honour of making a recommendation to a district court judge that a woman be made a care recipient under IDCCRA, and she was subsequently the first care recipient in New Zealand. From that first day I began to ask myself what impact this unique legislation was going to have on the lives of intellectually disabled people who were now considered criminal and disabled and already experiencing discrimination. I also wondered whether the legislation was justified in terms of the small number of likely recipients. I wondered about the decision on the part of the government to do something that was so different to comparable Western jurisdictions. Coming from a social justice perspective and working with offenders who were effectively subject to a criminal sentence created a philosophical tension for me that I believe is absolutely necessary to work in this area. Where freedom is limited, the protection of rights needs to be questioned constantly. I firmly believe that controls and risk management strategies need to be in place when dealing with a group that places others at risk, but these need to be measured against choice and appropriate freedoms.

This prompted my decision to explore options to engage in research specifically examining the impact of the IDCCRA on the lives of care recipients. For me, it was important that the views of care recipients were included. It was also important that any research I engaged in had the ability to critique social and power structures that serve to marginalise people with intellectual disabilities in our society.

Over the last eight years I have examined a number of publications considering the issues presented by the legislation. As described in Chapter Two, a number of authors have considered rights issues and the impact on the lives of care recipients as disabled people. Much critique has been provided in relation to the ability of the court to extend orders and whether the IDCCRA effectively provides arbitrary detentions. Specific cases have been discussed in relation to areas of the statute that require development or revision. I have also observed a theme that has concerned me; that is, a lack of consideration of the very real potential for harm to others presented by a number of care recipients who have been charged with serious, namely imprisonable, offences. However, it is important to note that this current study does not seek to minimise in any way the harm that has been caused by care recipients as offenders.

Rationale

Of primary importance for the current research is the fact that no research has been conducted that is inclusive of the views of the care recipients as well as service providers. Recent literature reflects the need to include the voice of disabled people within research in a philosophy of ‘nothing about us without us’ (Hammel et al., 2008; Shakespeare, 1998). Furthermore, several authors, such as Bonardi (2009) and Prebble et al. (2013), have cited the need to include the views of people subject to the IDCCRA in the context of research consideration of the legislation. In addition, at the time that I began this study there had been no research exploring the view of service providers working under the IDCCRA.

Methodology

Qualitative research was chosen based on a desire to explore the experiences of care recipients and service providers, rather than consider issues such as recidivism rates or

provide a critique of case law, the latter of which has dominated the literature in relation to the IDCCRA. Distance and objectivity is a necessary part of quantitative research (Gilgun, 2005; Parker, 2004). In contrast, qualitative research allows an interaction between the researcher and participant which provides the opportunity for theory building (DePoy & Gitlin, 2005). Qualitative research involves exploring meaning within a particular context and requires an active engagement with the data (Willig, 2001). I was more interested in what it meant to care recipients and service providers to be placed under the IDCCRA and the impact it had on their lives. I was also interested in examining their experiences within a social, political and historical context. To do this I chose a social constructionist methodology.

The current study also uses a social constructionist discourse analysis that is unique in terms of an examination of the IDCCRA. Social constructionism proposes that events do not have meaning in and of themselves but are inscribed with meaning within the context from which they are produced and understood through the interactions we have with others (Crotty, 1998; Hall, 2001). If, for example, we examined the lives of people with intellectual disabilities during the time of institutional care for disabled people in the early and mid-1900s, our understanding of them would be within the context of a hospital or medical environment. During this time, people with intellectual disabilities were considered in need of care within an institutional environment based on their inability to function in what was considered a 'normal' way (Bray & Gates, 2003; Munford & Sullivan, 1997). In contrast, an examination of the lives of people with intellectual disability today in New Zealand would find them located in a community environment with a stronger focus on support needs and participation in their community. This situation provides a different understanding of people with intellectual disability, as members of a community (Milner, 2008).

The intention is that by examining the social context for care recipients, the context can be critiqued in a manner that provides new and different understandings of care recipients as intellectually disabled offenders. No social constructionist research has been completed on this topic to date.

Terminology

For the purpose of this study a number of terms have been used in a particular way.

1. Intellectually Disabled Offenders – This is a term used to describe people with intellectual disabilities who have been charged with a criminal offence. This term is used throughout Chapter Two and Three particularly in terms of locating the current study within the literature.
2. Care Recipients – This explicitly refers to individuals subject to the IDCCRA. It has a very specific legal meaning and will be described in terms of the participants who were or had been under the IDCCRA and includes those who were participants in this study.
3. Service Providers – This is a generic term that will be used in relation to both the range of services provided under the IDCCRA framework and the participants in the study who were not care recipients. These individuals came from a broad range of backgrounds including legal, nursing, psychiatry, management and psychology. The term is used intentionally to protect the anonymity of the participants who fulfil a range of specific roles under the IDCCRA framework.

Other terminology will be described in Chapter Three.

Aims

The research goal was to identify and analyse the discourses that were evident in the words of the politicians at the time that the IDCCRA was passed in 2003 and then later in the words of the participants in 2010. By identifying these discourses the study aimed to reveal the subject positions and discursive practices that care recipients and service providers were subject to and the impact of these on their lives. A further goal was to identify any counter discourses that offered alternative subject positions and practices for care recipients and service providers. By identifying any counter discourses it was intended that they would be made visible and would open opportunities for different understandings of care recipients that might accord them different possibilities and power relationships. A final aim was to examine implications for practice that arose out of analysing discourses; for example, how could the framework provide rehabilitation to care recipients as intended?

Chapter Overview

During the time that I have been engaged in this study a number of research projects have been conducted. They have identified some important themes, such as the tension between managing risk and providing rehabilitation, and the challenges of providing compulsory care within a disability support environment. These will be explored further both in Chapter Two in terms of the literature and throughout the thesis in terms of the identified discourses. Chapter Two also explores literature that informed and provided context to the current study.

Chapter Three provides further context in terms of historical philosophical shifts that occurred for intellectually disabled people and led to the development of the IDCCRA. This chapter will detail some of the key government reports and publications in relation to the

development of the Act. Lastly, Chapter Three describes the key functions and roles of the IDCCRA.

Chapter Four provides comprehensive detail regarding the methodological base for the study. As already noted, qualitative social constructionist method was utilised along with a discourse analysis. Chapter Four also details issues that needed to be considered in two areas of ethical tension: the first was the consideration of issues related to intellectually disabled people as a vulnerable and marginalised group; the second related to my engagement in this research in a dual role of researcher and professional. Ethical approval was sought through the New Zealand Northern Regional Health and Disability Ethics Committee and approved prior to the commencement of the research project (NTX/10/04/029).

In Chapter Five I identify the dominance of an intellectual disability discourse that was both evident in the parliamentary debates in 1999 and 2003, and in the words of the participants in 2010. An intellectual disability discourse positioned care recipients in this study as ‘permanently impaired’, ‘vulnerable’ and ‘risky’. Service providers in the study were constructed as being in a parental role, with control and authority over care recipients. Supports provided by service providers were focused on disability support needs and impairment, and consequently, rehabilitation with a focus on community integration was rendered invisible. Opportunities for improvement became limited. Also identified is the fact that a new identity of intellectual disability is created for some individuals who had limited involvement in disability services prior to coming under compulsory care.

Chapter Six examines the manner in which the criminal discourse constructs care recipients and service providers in the study. Subject positions such as ‘criminal’ and ‘person doing time’ were offered, with support strategies focused on containment and risk management. Again, a new identity is constructed for some care recipients who, prior to the

IDCCRA, had their behaviour constructed differently. Following the IDCCRA and the charging of individuals, their behaviour was considered criminal. In effect, the IDCCRA has allowed for new identities to emerge. Particular attention is given in this chapter to techniques of disciplinary practice as described by Foucault (Foucault, 1977a). The intention of disciplinary practice is to modify the behaviour of care recipients to match that of non-offenders. The criminal discourse, like the intellectual disability discourse, has the effect of shutting down rehabilitation as strategies of containment and risk management provide little opportunity for improvement.

Chapter Seven identifies a counter discourse to the intellectual disability and criminal discourse that I name a capable person discourse. A capable person discourse provides alternative subject positions and constructions to the care recipients in this study. Instead of permanently impaired, risky, dangerous and in need of control, a capable person discourse constructs care recipients as capable and having the potential to live an ordinary life. A capable person discourse provides the possibility of rehabilitation that both supports the individual to improve offending behaviour and facilitates community integration for care recipients to live a life just like any other person.

Chapter Eight will provide a critical examination of the findings in the context of the literature and policy development described in previous chapters. The implications of identifying counter discourses will be discussed in the context of providing rehabilitative outcomes to care recipients. The significance of the findings is described in relation to the ongoing development of the IDCCRA framework. Also suggested is the consideration of care provided under IDCCRA in the context of broader disability imperatives and the United Nations Convention on the Rights of Persons with Disabilities. A new model of care will be

briefly described. Recommendations are made for research, education, policy and practice that will add to the field of knowledge on the IDCCRA.

CHAPTER 2 – LITERATURE REVIEW

Introduction

This chapter explores literature that informed the current study and demonstrated the need for research examining the impact of being under the IDCCRA for both care recipients and service providers. Relevant literature from Australia, the United Kingdom, New Zealand and Norway has been explored. Scholarship reflects the dominant issues for intellectually disabled people who engage in offending behaviour and become subject to the justice system either in the community or in prison. In Chapter Two human rights issues for this group will be explored in the context of the United Nations Convention on the Rights of Persons with Disabilities. Firstly, I will briefly describe the New Zealand context for intellectually disabled people, and then I will explore the literature in terms of how this group has been managed within the criminal justice system. I will then examine diversionary systems that have been developed for this group, with a brief exploration of the IDCCRA as a diversionary system. Finally, I will explore rights issues for intellectually disabled people.

New Zealand Context for People with Intellectual Disabilities

Deinstitutionalisation

A process of deinstitutionalisation has taken place for intellectually disabled people over the last thirty years (Milner, 2008). Deinstitutionalisation refers to moving individuals from long stay psychiatric and psychopaedic hospitals into the community (Johnson, 1998). The process of deinstitutionalisation was enacted to provide an improved quality of care and greater level of community integration for people with intellectual disabilities by physically locating them in the community (O'Brien, Thesing, & Capie, 1999). It was considered that

institutions provided conditions of social control and dependency for intellectually disabled people and that a change in location would alleviate these conditions (Taylor, 2005).

The notion of community, although somewhat debated, generally refers to either individuals living within a specific geographical location or individuals who are brought together for a common goal or interest (Leighton, 1988). Concepts of community participation draw on the notion that disadvantaged groups have a right to participate in their communities (Rifkin & Pridmore, 2001).

The move from institution to community may be viewed as a change in location for service delivery rather than a change in the way that people with intellectual disabilities have been both conceptualised and supported (Milner, 2008). Bray and Gates (2003) noted a level of naivety in the process of deinstitutionalisation in assuming that alternative living provisions, such as group homes, would achieve full community participation for intellectually disabled people. It is indeed possible for conditions such as control or dependency to exist in the community in a different but nevertheless powerful form (Taylor, 2005). As Bray and Gates argued, placement *in* the community does not equal *inclusion* in the community as people with intellectual disabilities still experience a high level of marginalisation.

An Australian study by Bigby (2008) randomly selected 24 individuals who had moved from an institution into the community. Data was collected via telephone surveys with family members and intensive case studies both prior to and following the move into the community. The findings of the study revealed that being “physically located in the community does not automatically provide any level of social inclusion and in fact social *exclusion* may become exacerbated by the aging process” (Bigby, 2008, p. 156).

An earlier paper by O'Brien, Thesing and Capie (1999) noted that the phenomenon of marginalisation was intensified for groups who were considered to have problematic behaviour. This is particularly relevant for care recipients who, by definition, have problematic behaviour that has brought them to the attention of the criminal justice system.

Driven by the goal of greater community integration for intellectually disabled people, New Zealand's Disability Strategy (Ministry of Health, 2001a) was published with a vision for a greater valuing of disabled people's lives and a community that enhances participation for all members. The Disability Strategy recognised the discrimination and marginalisation that exists for people with intellectual disability. It provided the framework by which government should draft policy and contract services in the best way for disabled people. More recently, in 2008, the United Nations Convention on the Rights of Persons with Disabilities has also provided a framework, which will be described in more detail later in this chapter.

Shortly following the advent of the Disability Strategy in 2001, the National Advisory Committee on Health and Disability was commissioned to examine the lives of people with intellectual disabilities. The goal was to establish whether they were accorded the same rights as non-disabled people and to what degree the goal of an 'ordinary life' had been achieved. The *To Have an Ordinary Life* (2003b) report concluded that many individuals with an intellectual disability are disenfranchised and that "services for adults with an intellectual disability in New Zealand are stagnating in respect of international best practice and, with some notable exceptions, are not moving in the direction of the New Zealand Disability Strategy" (2003b, p. 17).

The report also concluded that deinstitutionalisation in New Zealand had been characterised by a "translocation" of the "life defining" social practices of institutions; that in

some ways institutional practice had been transferred to the community. They also identified that “custodial and constrictive” service provision had followed people with an intellectual disability into community-based settings, with their lives being restricted in an unjustified manner (Milner, 2008; 2003b, p. 8). Restrictive practices are likely to be relatively more intense when dealing with intellectually disabled individuals who engage in offending behaviour.

People with Intellectual Disability Subject to the Criminal Justice System

One researcher, Susan Hayes, provided significant research in relation to intellectually disabled offenders. In a 2007 paper examining the Australian jurisdiction, Hayes identified what she perceived as the key issues for the intellectually disabled offender group. These issues were also identified in New Zealand-based research that will be described later in this chapter. The issues identified by Hayes provided a good framework for an examination of the literature in this area with a specific focus on the New Zealand context. These areas included “better identification of this group, increased education and training for criminal justice personnel, more opportunities for diversion from the criminal justice system, and better services in the community and secure units or prisons, to meet their needs” (Hayes, 2007a, p. 146).

Identification and Prevalence

Hayes conducted a number of research projects in Australia and the United Kingdom regarding both the prevalence and complexities arising from people with intellectual disabilities subject to the criminal justice system. One study, completed in 1997, found that although people with intellectual disabilities represented 2-3% of the Australian population at that time, in fact 23.6% of the people screened who were subject to criminal proceedings

during the study and/or who were imprisoned met the criteria for intellectual disability (Hayes, 1997, p. 81). The study used clinical screening tools with volunteers who were appearing in local courts in both urban and rural areas to establish whether they met the criteria for intellectual disability. ‘Hayes and colleagues also undertook research in the United Kingdom to determine the number of inmates in a Liverpool men’s prison who met the criteria for intellectual disability, based on a 10% sample of 140 inmates (Hayes et al., 2007). Using two standardised screening tools, the WAIS-III and the VABS, they found higher numbers meeting the criteria for intellectual disability, with 7.1% and 10.1% respectively, than had previously been found in the United Kingdom. This was consistent with Hayes’ finding that 20% of Australian prisoners had an intellectual disability (Hayes, 2000b).

Studies that indicate a level of overrepresentation for people with intellectual disability illustrate the need for robust legal processes in relation to intellectually disabled offenders with a focus on safeguarding the rights of this group. In a chapter titled “Legal Rights and Persons with Intellectual Disabilities” Marinos, Griffiths, Gosse, Robinson, Olley and Lindsay examined the rights of people with intellectual disability as they became subject to the legal system in Canada, the United States and the United Kingdom and identified that they were overrepresented within the criminal justice system (2009, p. 125). The authors proposed that people with intellectual disability needed appropriate accommodations to ensure engagement and understanding of the process. In the absence of social supports and accommodations, the authors concluded that the “legal rights of persons with intellectual disabilities” could be breached (Marinos et al., 2009, p. 150).

The reasons for overrepresentation of intellectually disabled people in the criminal justice system are complex and varied. In an early report in the Australian setting by the New

South Wales Law Commission (1996), reasons cited for the overrepresentation included experiences of institutionalisation meaning that individuals were inadequately prepared for community life, had poor communication, experienced social isolation and lack of access to recreational activities. Absent or poor service coordination was also mentioned. The New South Wales Law Commission further sought to establish whether overrepresentation in prison was reflective of the number of intellectually disabled offenders presenting in court or, in fact, reflective of a high number of custodial sentences for this group. The latter was established, and the lack of alternative support services was cited as one reason for the level of incarceration (New South Wales Law Commission, 1996).

Other barriers to engagement in the legal system were identified by research across the Australian and United Kingdom jurisdictions for intellectually disabled people. These were comprehension of the process (Cant & Standen, 2007; Hayes, 2005), ability to instruct a lawyer (McGillivray & Waterman, 2003), and negative attitudes demonstrated by people involved in dealing with intellectually disabled offenders (Chan, French, Hudson, & Webber, 2012).

Two recent reports raised awareness at a governmental level in the United Kingdom regarding issues for intellectually disabled offenders. The Bradley Report (2009) examined the criminal pathway for people with mental health issues or learning disabilities. The purpose of the report was to “undertake a six-month independent review to determine to what extent offenders with mental health problems or learning disabilities could be diverted from prison to other services and what were the barriers to such diversion”(Bradley, 2009, p. 4). The Prison Reform Trust’s No One Knows project, also from the United Kingdom, aimed to effect change by raising awareness regarding the experiences of people with learning difficulties going through the criminal justice system. Based on a three-year review of the

criminal justice system, the project found that the needs of intellectually disabled offenders relating to issues such as comprehension and communication are often not recognised, let alone met (Talbot & Jacobson, 2010).

Both reports made a number of recommendations that were consistent with the issues identified by Hayes (2005) and the NSW Law Commission Report (1996) regarding early identification of people with intellectual disabilities subject to the criminal justice system, raising awareness for criminal justice staff, addressing poor service provision, and rights protection for the intellectually disabled offender group. The recommendations were further supported by New Zealand-based research and are detailed later in this chapter. The interactions that intellectually disabled people have whilst going through the criminal justice system have a significant impact on their experience of the legal process (Bradley, 2009). If efforts are not made to ensure they understand the process, then it is likely to be a negative experience (Mirfin-Veitch, Diesfeld, Gates, & Henaghan, 2014).

Differential Treatment

One of the most common reasons cited in the literature for the overrepresentation of intellectually disabled offenders in the criminal justice system was differential treatment; that is, that people with intellectual disabilities are treated differently in comparison to non-disabled people (Talbot & Jacobson, 2010).

Research in various jurisdictions highlighted the impact that the attitudes of professionals involved in the criminal justice system can have on outcomes for intellectually disabled offenders. For example, a United Kingdom qualitative study by Cant and Standen (2007) explored the attitudes of professionals working within the criminal justice system regarding people with intellectual disabilities. They carried out 28 semi-structured interviews

involving a range of professionals. Two themes emerged from the grounded theory research: one focused on the specific needs created by having a learning disability and the need for reform of the legal system to better meet these needs; the second theme reported participants' perceptions that there was little ability for the system to change (Cant & Standen, 2007). This represents a fairly negative view of the situation regarding the needs of intellectually disabled people. By perceiving little opportunity for change, the participants articulated that the situation was likely to remain the same for intellectually disabled offenders. Whilst this study provided some useful reflections regarding the attitudes of professionals, it did not provide an analysis of the socio-political context. Using a social constructionist lens, the current research will explore the social, historical and political context to the subject positions enacted for care recipients as intellectually disabled offenders.

A similar Australian study conducted by McGillivray and Waterman (McGillivray & Waterman, 2003) sent out a questionnaire to 96 criminal lawyers to assess their levels of knowledge regarding intellectual disability. They found that many criminal lawyers had some understanding of some of the issues faced by intellectually disabled offenders. They also identified that a lack of knowledge on the part of legal professionals regarding intellectual disability was problematic as it could lead to increased levels of vulnerability for their clients.

A similar New Zealand based study by O'Brien, Miller-Burgering, & Vickery (1999) analysed questionnaires from 138 respondents including lawyers, police and forensic nurses to assess their levels of knowledge and attitudes towards people with intellectual disabilities. They found that communication difficulties provided the most significant challenge in terms of achieving the best outcome for the individual involved. Communication difficulties were particularly evident in relation to the intellectually disabled offenders' understanding of the court process and their ability to instruct their lawyers. The study found that, in general, court

staff in New Zealand had a neutral to positive attitude to intellectually disabled offenders and were of the belief that it was necessary to provide specific accommodations throughout the legal process for intellectually disabled offenders. It also highlighted the need for any communication difficulties to be addressed effectively throughout the process to ensure the rights of the intellectually disabled offender were upheld.

A more recent New Zealand study explored the experiences of people with intellectual disability in the legal system. The research identified a need for education of legal professionals, particularly in relation to “skills in interviewing and questioning clients” (Mirfin-Veitch et al., 2014, p. 67). Whilst the study took a broader view of the legal system in relation to intellectually disabled people, it was similar to the current study in that it included the views of care recipients subject to the IDCCRA. Mirfin-Veitch and colleagues interviewed three groups: judges (n = 13), lawyers (n = 15) and people with intellectual disability (n = 40) (p. vi). Of relevance to the current research, the 2014 study identified that a number of people subject to the IDCCRA had never previously been involved with intellectual disability services.

All judge participants in the study by Mirfin-Vietch and colleagues (2014) identified the vulnerability of people with intellectual disability within the New Zealand legal system. The judges also identified a level of disadvantage for intellectually disabled people in the legal system. All participants were consistent in the view that the legal system needed to be more responsive to the needs of people with an intellectual disability. Like previous research, both groups recognised the importance of communication, including listening to people with intellectual disabilities. Also, information had to be imparted by lawyers, judges, police and carers in a fashion that was comprehensible to people with intellectual disability. Education such as disability awareness training was considered vital for legal professionals.

One recommendation from Mirfin-Veitch et.al, (2014) was the creation of a specialist disability court with mandatory training in intellectual disability. In contrast with the current adversarial approach in New Zealand criminal proceedings, the proposed court could adopt a less adversarial approach, which would better “accommodate the needs of people with intellectual disability” (2014, p. 67). Another finding of the research related to the incidence of abuse experienced by participants. This issue will be explored in more detail later in this chapter.

A recent qualitative descriptive study with focus groups in Australia by Douglas and Kuskelly (2012) illuminated how police officers detected whether a person had an intellectual disability. The study found that many police officers identified individuals as having an intellectual disability based on their appearance and demeanour. It is likely that stereotypical features commonly associated with people with intellectual disabilities would have been utilised in identifying individuals as having an intellectual disability. The consequence of this was that a significant number of individuals who did not fit the stereotypical features would have not been offered appropriate accommodations and support (Douglas & Kuskelly, 2012). A screening tool was recommended as an effective means of ensuring an appropriate identification and response by police officers.

It is also likely that stereotypical assumptions could be applied to a number of minority groups by court staff. In a New Zealand context this has an impact for Māori, who may be subject to a number of stereotypical assumptions about their behaviour and character that in turn has been found to disadvantage them (Department of Corrections, 2007).

Tangata Whenua (Māori)

Māori are overrepresented in the mainstream offender population in New Zealand (Department of Corrections, 2007; Durie, 2007; Morrison, 2009) and the disability population (MacPherson, 2014). They are also overrepresented amongst the care recipient population subject to the IDCCRA in New Zealand (Daysh, 2008; Duncan, 2013). This is further demonstrated in Chapter Four based on reports that in 2014, out of 128 individuals under compulsory care, 46 were Māori. Thus, 36% of the IDCCRA population was Māori, although nationally only 14.9% of the general population identified as Māori in the 2013 New Zealand Census (Statistics New Zealand, 2013).

In terms of the non-disabled offender population, a report by the Crime Prevention Unit in 2000 explored the responsiveness of the criminal justice system to Māori in New Zealand. The project reviewed international literature and a selection of New Zealand-based intervention programmes to make recommendations regarding a more responsive legal system for Māori. The research found the following:

Māori were over-represented at every stage of the criminal justice process. In 1998 they were 3.3 times more likely to be apprehended for a criminal offence than non-Māori. They were more likely to be prosecuted, more likely to be convicted, and more likely to be sentenced to imprisonment. The result was that Māori made up 14% of the general population and 51% of the prison population. (Doone, 2000, p. 8).

The Doone report on *Combating and Preventing Māori Crime* (2000) recommended that the New Zealand Government needed to address Māori offending rates through both increasing responsiveness to Māori and working to decrease the “gaps between Māori and non-Māori in underlying risk factors which contribute to crime” (p. 8). Risk factors related to

issues such as unemployment, misuse of drugs and alcohol, poor developmental experience and low socio-economic status (p. 10).

A later report for the Department of Corrections also sought to explore why “Māori are disproportionately represented in criminal justice statistics to an alarming degree” (Department of Corrections, 2007, p. 4). The *Over-representation of Māori in the Criminal Justice System* report considered two primary explanations. The first was that bias operated at all junctures of the criminal justice system for Māori offenders. Bias related to the judgemental attitudes of police and court staff and discriminatory practices throughout the court process (Doone, 2000). The second was that Māori were over-represented for a number of risk factors based on “a range of adverse early-life social and environmental factors [that] result in Māori being at greater risk of ending up in patterns of adult criminal conduct” (Department of Corrections, 2007, p. 4).

A later report for the Ministry of Justice by Morrison (2009) examined the issue of over-representation regarding ethnic minorities across several Western jurisdictions such as Australia, Canada, England and Wales, the United States, and New Zealand. The Justice report identified that “both international and New Zealand research has consistently shown that certain ethnic minority groups are disproportionately represented in adverse criminal justice outcomes at successive stages of the criminal justice system”(Morrison, 2009, p. 12). The review also noted that the degree of over-representation was not consistent across differing demographics, such as socio-economic status, which highlighted the need to consider context in terms of any recommendations. In essence, factors such as age, gender and socio-economic status also had an impact on levels of bias that were evident (Morrison, 2009).

There is no research currently exploring the specific experiences of intellectually disabled offenders who are Māori. Documents such as the Disability Strategy (2001a) identified gaps that exist for Māori with disabilities and articulated the need for current disability policy to be reviewed in light of the needs of Māori (Wiley, 2007). It is further argued that disabled Māori are often faced with double discrimination in a society that marginalises them both in terms of their culture and their disability (Wiley, 2007).

As already mentioned in this chapter, Māori are over-represented under the IDCCRA, which is consistent with over-representation amongst the non-disabled offender population. It is likely that issues such as bias and contributory risk factors provide a further complexity for care recipients and people with intellectual disability. Also, it is likely that Māori with intellectual disability are subjected to bias on the basis of disability and ethnicity.

Female offenders

A policy issue for the IDCCRA was how to address humanely the unique issues that female offenders with an intellectual disability present for both the criminal justice system and accompanying service provision under this legislation (Daysh, 2008). Various authors argued that due to the small proportion of women with intellectual disability in the criminal justice system, their particular needs are neither identified nor met. According to Duff and Sakdalan, “ID multiplies all the difficulties of addressing the needs and rehabilitative goals for women in general within the existing prison system, designed primarily for male offenders” (2007, p. 355).

A study by Hayes (2007b) of female prisoners with learning disabilities in Australia found that female prisoners were more likely to be poorly educated, financially impoverished

and victims of abuse. Hayes posits that the voices of these women first need to be heard so that the experiences they have with the criminal justice system can be revealed:

In order to address the dearth of information about women offenders with learning disabilities, collaborative research and pooling of results must occur to enable researchers to draw meaningful conclusions about this small sub-group in the offender population, which will in turn inform those who are advocates for this group. (p. 190).

A study by Lindsay, Steele, Smith, Quinn and Allan (2006) examined the long-term outcomes provided for women by a community forensic service. The research reviewed the “characteristics of women in the criminal justice system; a comparison of characteristics and provision for women in relation to men” (Lindsay et al., 2006, p. 115). The study found higher rates of mental illness and a range of other social problems for intellectually disabled female offenders indicated a significant level of complexity for this group (p. 115).

The current study included women who had been placed under the IDCCRA. In identifying discourses deployed under the framework, contextual issues such as gender and ethnicity needed to be considered. This was particularly important in considering how intellectually disabled offenders should be supported in order to provide the best outcome. If services do not consider the needs of female offenders, then those needs are unlikely to be met.

Management of Intellectually Disabled Offenders

The Role of Services in Reducing Offending

Lindsay et al.’s (2006) study in Scotland not only focused on women but examined outcomes more broadly provided by a community forensic service supporting intellectually disabled offenders. Outcomes were explored for 247 individuals with an intellectual disability

over a twelve-year period. Participants had all been subject to criminal justice and/or mental health legislation. Information for the study was gathered from case file information, case review meetings and individual interviews (p. 117). Results indicated some reduction in reoffending rates. The researchers concluded that support and management in the community under a forensic intellectual disability service could, in fact, have some impact on reducing reoffending over a twelve-year period (Lindsay et al., 2006, p. 114). The service provided a range of inpatient, outpatient and day services. Similar services are provided under the IDCCRA framework, with both hospital-level secure and community services provided. The study highlights the importance of clinical monitoring subsequent to release from compulsory care to ensure that any risk of reoffending is minimised. This has relevance for care recipients who, as identified in Chapters Five and Six, may find community reintegration challenging.

Another United Kingdom study, by Alexander, Crouch, Halstead and Piachaud (2006), also examined the long-term outcomes for people released over a twelve-year period from a medium secure service for people with intellectual disabilities. The study compared two groups who had been discharged during two different time periods (1987-1993 and 1994-2000). A structured questionnaire was used with discharge patients in addition to case-note analysis. The results showed a reduction in reoffending rates when compared with general forensic services (Alexander et al., 2006). However, the researchers concluded that the reduction may in part have been the result of more effective behaviour management strategies leading to reduced police involvement. Whilst these studies provided some useful results regarding recidivism rates following a forensic treatment programme, they did not provide any analysis of the context that these individuals came from or were placed in following discharge.

A United Kingdom study by Barron, Hassiotis and Banes (2004) compared outcomes for 61 individuals who fell into two groups of intellectually disabled offenders: the first group included people who had been identified as having intellectual disability and had received specialist intellectual disability services (Barron et al., 2004, p. 70); the second group comprised intellectually disabled offenders who had not been in receipt of specialist services. The findings were that the second group had “significantly higher IQs and were less likely to have had contact with community social and health support agencies” (p. 69). The authors also found “little evidence for efficacy of therapeutic interventions, which, where offered, appeared to be of a nonspecific nature” (p. 69). The authors viewed that it had been difficult to develop specific programmes due to the low numbers of intellectually disabled offenders within the region (p. 74). Issues such as programme development and the effectiveness of therapeutic interventions have relevance for the current research.

Staff Management and Support of Intellectually Disabled Offenders in New Zealand

Nursing and other care staff that provide care to intellectually disabled offenders face a number of unique challenges, and need for specialist training was highlighted by the following research. A qualitative descriptive study by Campbell (2005), whilst not specifically focusing on intellectually disabled offenders, explored issues related to nurses working in an environment where they were subjected to frequent violence. The environment researched included care recipients under the IDCCRA. Campbell found that exposure to violence had a significant impact on nursing staff and that proactive support systems were essential to alleviate the impact of the exposure. This study highlighted the need for specialist skills and training in this area (Campbell, 2005).

The need for specialist training for service providers was also highlighted in a New Zealand study by Brandford (2000), from which a report was provided to the Health Funding

Authority on the implementation of best practice for people with high and complex needs. Brandford argued that a lack of specialist services led to more punitive strategies for intellectually disabled offenders who may have ended up in the criminal justice system as a result. This was supported by a later New Zealand analysis by McLean and Hartnett (2005), who argued that a lack of specialist services, poor service delivery and a lack of community options had led to increased levels of offending, with many arrests happening from within services.

A similar study by Holmes (2005) used grounded theory and the work of Foucault to explore the role of nurses within a forensic psychiatry ward in Canada. Whilst this did not specifically focus on offenders with an intellectual disability, it provided some relevant commentary for forensic intellectual disability services. Holmes found that nurses were subject to a complex negotiation of their roles. Nurses had a legal responsibility to maintain control of patients while at the same time providing nursing 'care'. Holmes stated, "Forensic psychiatric nurses need to be cautious that their approach to patients does not reinforce the stigma and discrimination of the wider community" (p. 7). Holmes considered it essential that service providers had an understanding of rights for people with an intellectual disability to reduce their marginalisation. McLean and Hartnett expressed that it was essential that individuals who work in a support role with intellectually disabled offenders' combat marginalisation (2005). The current study will explore the impact of working with intellectually disabled offenders on the service providers.

Diversionary Systems

Issues for Diversionary Systems

The need for an alternative pathway for intellectually disabled offenders has been identified by numerous authors, such as Hayes (2006) in Australia, and Talbot and Jacobson (2010) in the United Kingdom. A diversionary system provides an effective alternative for intellectually disabled offenders whose needs will not be met within the usual criminal justice system processes and prison environment (Hayes, 2007a). Hayes (2006) also noted that it is essential that an alternative pathway provides more community-based or secure options for intellectually disabled offenders. Without such a system, prison becomes the option for this group (Talbot & Jacobson, 2010). In considering an alternative pathway, the needs of intellectually disabled offenders are complex. The process of providing a diversionary system for intellectually disabled offenders does mark them as different from non-disabled offenders based on their vulnerabilities and differential needs as disabled people.

Many intellectually disabled offenders reflect similar demographics to the mainstream offender population, being young and male (Barron et al., 2004). Other studies have found that intellectually disabled offenders were also likely to have a history of abuse and neglect and alcohol and drug dependency problems (Inglis & Dale, 2010). Like mainstream offenders, intellectually disabled offenders were often from impoverished environments with social and financial disadvantages (Frize, Kenny, & Lennings, 2008). These issues have also been identified in the New Zealand context by Mirfin-Veitch et al. (2014). Similarly, Duncan (2013) noted these issues for a group of young offenders that he viewed as emerging under the IDCCRA. As will be explained in Chapters Five and Six, these issues were also identified in the current study.

It is vital, however, that the exit strategies provided by a diversionary system include adequately resourced and effective options because only then will they be utilised (Vanny, Levy, & Hayes, 2008). This was supported by later research completed by Talbot and Jacobson (2010), who examined the concept of effective partnership for adult defendants with a learning disability within the criminal justice system. They commented that any diversionary system will only work if “there is adequate provision of services for vulnerable defendants across, and beyond, the criminal justice system, and if the policy framework fully supports these services” (Talbot & Jacobson, 2010, p. 24).

A descriptive study in Norway by Sondena, Linaker & Nottestad (2009) explored the impact following a change in legislation that “redefined which persons with an intellectual disability (ID) are considered to be offenders within the judicial system” (p. 229). Similar to New Zealand following deinstitutionalisation, Norway had a lack of specialist services available for intellectually disabled offenders who committed “serious violent crime, sexual offense, or life threatening arson” (p. 230). Such offenders were either incarcerated in prison or became subject to a sentence of preventative supervision in the community.

Like New Zealand, Norwegian legislation separated mentally unwell offenders from intellectually disabled offenders (Sondena et al., 2009). This legislation allowed for mandatory care for intellectually disabled offenders who committed serious offences and were considered at high risk of reoffending. Similar to the IDCCRA in New Zealand, the legislation was limited to those who had been charged with serious offences.

In contrast to the IDCCRA, the Norway legislation applied restrictive criteria around access for mandatory care to “serious and life threatening crime by a person defined as nonresponsible due to ID with an intellectual functioning corresponding to moderate or severe ID (IQ<55)” (Sondena et al., p. 230). What this meant in practice was that a number of

intellectually disabled offenders still received prison sentences, due to the IQ threshold for access being lower than in New Zealand. The authors did note that there was an option of reduced sentences for intellectually disabled offenders. In New Zealand, access to the IDCCRA requires an assessment and diagnosis of intellectual disability, with no restrictions in place in terms of severity of disability. The assessment of an intellectual disability has clear criteria as stated in the Act and will be discussed further in Chapter Three. The Norway legislation indicated an intention to provide alternative disposition options for a small group of offenders who would have little understanding of the consequences of their offending and would present considerable vulnerability in the prison setting. The IDCCRA governs a broader group of intellectually disabled offenders in respect of vulnerability.

The Norway study gathered information from service providers, case notes and the criminal register. It examined issues such as offending type, behavioural problems, participation in activities, access to specialist health services, living conditions and costs (p. 230) for two identified groups. A comparison was conducted between 27 intellectually disabled offenders who had been sentenced to preventive supervision prior to the new legislation and 17 individuals who had been placed under mandatory care under the new legislation (Sondena et al., 2009).

Sodena et al. found that, following the advent of the new legislation, “offenders with ID appeared to be managed by more qualified staff, but ...had less contact with health services outside their residence” (p. 229). They noted this may have been due to the involvement of qualified health staff within the service. They also noted an “attitude of ‘containment’ among the staff, in terms of not wanting outsiders intervening in staff practices or directly with residents” (p. 234).

The Soden et al. study also found a greater level of restrictive practices for the group under mandatory care legislation, with less engagement in community-based activities that required a greater level of monitoring (p. 233). They concluded that “staff seemed too concerned with safety measures and too little focused on rehabilitation” (p. 234). These findings have significance for the current study, which identified a similar tension between managing risk whilst attempting to provide effective rehabilitation and community integration for care recipients.

In the Australasian context, Lim and Day (2013) considered the efficacy of mental health diversionary courts in Australia. They stated that the underlying principle of these courts is to promote well-being, but that within the context of the court, the principle of wellbeing does not override traditional goals of “punishment, deterrence and community protection” (p. 37). Like the IDCCRA, the aim of the mental health diversionary system was to meet both sets of goals and provide a better coordination between justice, health and disability services (p. 38). Lim and Day (2013, p. 38) focused specifically on the Magistrates Court Diversion Programme in South Australia. They concluded that diversionary courts of this kind are intended to assist the court in dealing more effectively with offenders who have a mental health difficulty. Whilst there seemed to be some evidence of an increased access to services, there was little evidence regarding the impact on reducing reoffending. It was suggested that well-defined risk reduction becomes a measure for success rather than an individual’s willingness to engage (Lim & Day, 2013). This has relevance for the current study, in which risk reduction is a primary focus within the care and rehabilitation provided under IDCCRA. Recent research focused on the IDCCRA provided interesting and consistent results.

The Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003

Three studies specifically examined the IDCCRA. A qualitative study using grounded theory was completed by Prebble et al. (2013), exploring the role of care managers under IDCCRA. The study investigated the role of care managers who have legal responsibility for the compulsory care of care recipients.

The Prebble et al. research identified a number of dilemmas for care managers. Dilemmas included role confusion between the need to manage risk and what they saw as an advocacy or support role. Ethical dilemmas also featured in terms of care managers' experiences of extensions of orders. Care managers also cited contradictions in their practice. These included meeting disability sector imperatives relating to community integration, the requirements of working with an offender population and lack of clarity regarding rehabilitation (Prebble et al., p. 122). The authors suggested that further research was needed with a specific focus on the experiences of care recipients (p. 122). The current study has included the views of care recipients. Also, the current study provides a broader view of the operational implementation of the IDCCRA through the range of different roles the participants held under the IDCCRA framework. In contrast to the research by Prebble et al., the current study undertook a discourse analysis based on the perspectives of many stakeholders in addition to care recipients.

Another study including the views of practitioners was conducted by O'Callaghan (2012) — a mixed methods study looking at recidivism rates for care recipients. O'Callaghan's research was distinctive in its use of both quantitative and qualitative data in the analysis of recidivism rates. The findings highlighted that whilst recidivism rates were perceived as being high by professionals involved in working with the IDCCRA, in fact they were relatively low, at a rate of around 15%. By comparison, a Department of Corrections study established a 52%

reoffending rate amongst 4,945 people released from prison in the 12 months to 31 March 2003 (Prison Task Group, 2010). In common with Prebble et al. (2013), O’Callaghan found that rehabilitation needed to be better defined and understood by those responsible for care and rehabilitation under the framework to provide the best outcomes for care recipients (O’Callaghan, 2012).

Another recent study, by Ngatai (2013), critiqued whether the IDCCRA had met the policy goals and objectives. These related to the provision of care and rehabilitation as defined when the legislation was passed. The study found that the “overall implementation of the IDCCRA [was] achieving its desired purpose” (Ngatai, 2013, p. 56). The author analysed court decisions regarding the assessment of intellectual disability under the framework. He indicated a need to review this area of the legislation:

In light of multiple decisions made in the Courts where the diagnosis of intellectual disability has been a focal issue, coupled with the fact that the criminal Courts cannot revisit sentencing after a convicted offender has been ordered under the IDCCRA, a thorough initial assessment of intellectual disability was viewed as being absolutely critical. (Ngatai, 2013, p. 56).

All studies to date that focused on the IDCCRA noted a tension between managing risks accompanied by the restriction of liberty versus meaningful rehabilitation with a goal of community integration. This was also described in a qualitative study by Bonardi (2009), who examined the risk management approaches utilised within New Zealand intellectual disability services. Bonardi conducted 39 interviews with individuals working in the disability sector. A review was also completed of provider specifications and contracts that described how services were to be provided by the providers.

Whilst examining intellectual disability services more broadly, Bonardi (2009) provided comment on IDCCRA specifically. Bonardi questioned the effectiveness of the framework in the absence of evaluation processes that measure service delivery and risk management against outcomes. Bonardi concluded that “the Ministry of Health should commission an external evaluation of the ID (CC&R)” (p. 87) for the purposes of striking a better balance between choice for care recipients and control by others under the framework. Of relevance for the current study, Bonardi also suggested that “the experience of care recipients will add to the body of evidence and provide useful programmatic information” (p. 87), which the current study has aimed to achieve.

Professor Brookbanks, a legal academic at the University of Auckland, has published extensively on mental health legislation, including research specifically focusing on the IDCCRA. Brookbanks’ most recent publication on the IDCCRA argued that the legislation is controversial, stating the following:

In large measure its controversial character lies in the legislature’s decision to enact a highly complex and prescriptive statute with no legislative history, and affecting a highly vulnerable group of people, creating the possibility of interpretive challenges in the court. (Brookbanks, 2013, p. 219).

Given care recipients’ vulnerability, Brookbanks (2013) noted the gravity of having explicit processes for providing assistance to assert their rights. Also, Brookbanks provided specific critique regarding the ability for compulsory care orders to be extended beyond the duration of the original term by the Family Court. He viewed this as a “highly coercive feature” (p. 219) of the legislation. Brookbanks reviewed the IDCCRA and case law, arguing that the ability to grant extensions resulted in allegations “that the statutory regime is

discriminatory, that it permits the arbitrary detention of those subject to it and that it fails to protect the rights of intellectually disabled offenders” (Brookbanks, 2013, p. 219).

This and similar scholarship has had a significant impact on the current study. As will be described in Chapter Four, the study’s inclusion criteria for care recipients were those individuals either nearing the end of their compulsory care orders or following the expiry of their orders. The purpose of this was to explore the decisions that were made regarding whether their compulsory care order should be extended or not. Service providers in the current study cited a tension between managing risks presented by care recipients and working to demonstrate the level of improvement required for them to move to greater independence. Diesfeld (2013), an extensively published author in the areas of mental health and disability law, published a chapter exploring the rights of care recipients within the context of the United Nations Convention on the Rights of Persons with Disability (UNCRPD). Diesfeld, like Brookbanks, based her comments on case law and an exploration of the IDCCRA. She noted the concerns by Brookbanks regarding the ability to grant extensions to compulsory care orders. Diesfeld supported the view that this feature was problematic in the context of rights for care recipients. She also presented an overview of her research with Prebble et al. (2013).

Diesfeld (2013) identified the unique nature of the legislation with the transfer of people with intellectual disability from the criminal justice sector to the disability sector. Also, she noted the potential for the legislation to lead to care recipients perceiving they were ‘doing time’ based on lengthy periods of compulsion determined by the Family Court (p. 241). The construct of ‘doing time’ for care recipients is a finding of the current study and will be explored in Chapter Six in the context of a criminal subjectivity offered to care recipients.

Of particular relevance for the current study, Diesfeld noted that “The CRPD, together with legal decisions and concrete guidance founded on its principles, may ensure that the purposes of the IDCCRA are achieved: rights protection and rehabilitation” (Diesfeld, p. 257). This view is supported in the findings in Chapter Eight, where it is argued that the needs of care recipients must be considered in the context of broader disability imperatives relating to community integration and rights protection.

Duncan (2013) provided an overview of the IDCCRA and described the legislative changes that led to its enactment. Duncan provided some brief statistics regarding the number of compulsory care orders that had been made to date: “As of December 2012, a total of 318 individuals had been made subject to CCOs (compulsory care orders) since the commencement of the IDCCRA in September 2004” (p. 361). He also stated that there had been “25 extensions of compulsory care orders during the time and that 220 had been either cancelled or had expired” (p. 361). Data such as this provided a contrasting view to that of Brookbanks (2013) and Diesfeld (2013), who asserted a “proliferation of renewals” (p. 257).

Duncan also identified what he considered an unanticipated group. Calling them “New Care Recipients” (p. 362), Duncan described them as young offenders who were unlikely to have been identified as having disabilities or having received support from disability services (2013, p. 362). Interestingly, Dawson anticipated this group in 1997 but believed the ordinary criminal process was more appropriate for this population (Dawson, 1997). Like Brookbanks (2013) and Diesfeld (2013), Duncan emphasised the importance of effective models of care, particularly in relation to the new care recipient group: “The legislation promotes the rehabilitation of this group of vulnerable and damaged offenders, and does not simply authorise their continuing, and possibly discriminatory, detention” (2013, p. 371). For all three authors, issues relating to rights protection for care recipients

were highlighted. As individuals who are subject to restrictions of liberty, the issue of rights is paramount for care recipients.

Rights for People with Intellectual Disability

United Nations Convention on the Rights of Persons with Disabilities

Several international instruments are highly relevant to the IDCCRA. For example, rights such as safety, equality before the law, participation in the community, freedom from torture and cruelty, equal access to employment and an adequate standard of living for health and well-being are enshrined under the Universal Declaration of Human Rights 1948. More recently, the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) has had particular relevance for intellectually disabled people (Chan et al., 2012).

New Zealand was one of the first to sign, and ratified the convention in 2008 (Human Rights Commission, Office of the Ombudsman, & The New Zealand Convention Coalition, 2012). New Zealand is required to report on progress against its requirements on a yearly basis. The first New Zealand report on the Implementation of the UNCRPD cited the New Zealand Disability Strategy as the basis for New Zealand's role in the development of the UNCRPD. It further stated that the UNCRPD is given effect through both the New Zealand Bill of Rights (1990), which specifically safeguards the rights of disabled people, and the Human Rights Act (1993), which is "antidiscrimination legislation which recognises disability as a protected class" (Diesfeld, 2013, p. 242). Consideration of these statutes was significant in terms of New Zealand's decision to ratify the UNCRPD (Human Rights Commission et al., 2012).

The UNCRPD reportedly required a paradigm shift from people's status as welfare recipients to a position of full citizenship. The UNCRPD has the potential to create

significant change to the involvement of disabled people in policy development. Accordingly, the implementation of the UNCRPD requires full participation of disabled people throughout the whole process, rather than just being consulted as an interested party (Hawker, 2010). According to Hawker, “Putting this into practice so that it is real and not tokenism will be one of the greatest challenges for practitioners” (Hawker, 2010, p. 1). Articles 12 (Equal recognition before the law) and 13 (Access to justice) have particular relevance for care recipients in the interests of “legislation, legal processes and practices that promote, rather than limit, the rights of disabled people” (Mirfin-Veitch et al., 2014, p. 1).

In 2009 the government established the Ministerial Committee on Disability Issues, a cross- government strategy to ensure the necessary leadership for the implementation of both the New Zealand Disability Strategy and the UNCRPD. Of particular note is that the UNCRPD focuses on the prevention of restrictive and compulsory interventions for people with disabilities (Chan et al., 2012). The UNCRPD is relevant because the IDCCRA authorises compulsory care for some people with an intellectual disability, and this has the potential to infringe on rights specified under the UNCRPD.

Canadian researchers Owen and Griffiths (2009) reflected upon the meaningful implementation of the UNCRPD. They suggested a rights education programme for individuals with an intellectual disability in Canada. They claimed that “A critical first step in protecting human rights is informing people about the nature of their rights” (p. 15). Said to be inspired by a desire to reduce the abuse of people with intellectual disability, the Canadian programme was developed by a group of community providers and researchers (Owen & Griffiths, 2009). The group supported a community agency to develop a mechanism for considering potential rights breaches in the context of an organisational human rights

statement (p. 16). Any potential violations then became a prompt for the education of service providers as to how they could work to uphold the rights of intellectually disabled people.

Owen and Griffiths (2009) noted an emerging tension between promoting self-determination and maintaining safety for intellectually disabled people. This observation is highly relevant to analysis of the IDCCRA and rights protection for care recipients from themselves and/or others. As noted by various authors above, the IDCCRA is restrictive by nature in that it provides compulsory care. Consideration of rights becomes significant where freedoms are limited for intellectually disabled people. Owen and Griffiths also note that once people with intellectual disabilities are informed of their rights, a ‘responsive infrastructure’ (p. 16) is essential. Addressing rights violations requires a framework to ensure the necessary changes occur.

Implementing a Rights Framework

Although not focused on intellectual disability, Australian scholarship has provided some insights in relation to implementing a rights framework. Research by Ward and Birgden (2007) argued that it was possible to implement a human rights framework within a correctional setting and articulated a model for doing so. Their recommendations for rights protection of the general forensic/offender population have direct relevance for care recipients.

Ward and Birgden proposed a model with three layers of human rights. The values of “freedom” and “well-being” were at the centre (Ward & Birgden, 2007, p. 634). These two values could then be translated into a number of human rights objectives such as equality, personal freedom and recognition. The third layer recommended that policies and rights be enshrined in law.

The above model and recommendations by Ward and Birgden (2007) were advanced by the work of Siegert, Ward and Playford (2010). The latter found that human rights and dignity had a direct impact upon outcomes for individuals within a rehabilitation service. They identified the core values of freedom and well-being (as described by Ward and Birgden) as “essential requirements for a person to be able to function as a purposive agent with human dignity” (Ward & Birgden, 2007, p. 969). These core values are both congruent with the UNCRPD and could well inform the implementation of supports under the IDCCRA framework.

Again in the Australian context, French, Chan and Carracher (2010) contemplated the implementation of the UNCRPD for clinical practitioners working with individuals with cognitive deficits and challenging behaviour. The authors asserted that disability had experienced a level of invisibility within broader human rights developments traditionally, and that this had been most significant with those individuals “with cognitive impairments who engage in behaviours of concern” (p. 246). This has direct relevance for the current study with care recipients who experience a level of marginalisation based on both their intellectual disability and their criminal behaviour.

The authors suggested that, in the context of the UNCRPD, both clinical staff and service providers in Australia needed to both *understand* human rights imperatives for people with intellectual disability and *apply* human rights effectively to the individuals they supported. Again, this has direct relevance for care recipients and the New Zealand context in terms of the UNCRPD.

The point above was reiterated in the intellectual disability criminal context by Chan, French, Hudson and Webber (2012). They considered the application of the UNCRPD for people with intellectual disability in the criminal justice system. The authors reported a lack

of research “that draws upon a human rights framework for supporting the dignity of these individuals while they are being supported in the community or are in incarceration” (p. 559). The ability for rehabilitation practitioners to be competent in the analysis of rights is essential because the individuals with disabilities may be subject to a range of restrictions.

The study by Mirfin-Veitch and colleagues (2014) examined the broader legal system within a New Zealand context for people with intellectual disability. The authors concluded that New Zealand was making efforts to implement and monitor the UNCRPD goals and objectives in New Zealand. The UNCRPD has specific articles relating to equal recognition before the law (article 12) and equal access to justice (article 13). However, the study found that these rights have not been fully realised in New Zealand. The study also found a high incidence of abuse experienced by participants, which is an ultimate breach of an individual’s rights.

Experiences of Abuse

The above study by Mirfin-Vietch et al. noted that half of the female participants and a third of the male participants with an intellectual disability disclosed experiences of abuse. The participants disclosed their abuse in the course of the interview, and it was considered likely that abuse was more prevalent than noted above (Mirfin-Veitch et al., 2014). The numbers of women in the study reporting abuse were reflected in earlier studies such as those by Hayes (2007b), who identified in a study of female prisoners with learning disabilities that most had experienced abuse. Scholarship regarding the abuse of intellectually disabled people was relevant to this thesis because of the position of dependence that is created for care recipients under IDCCRA. Research indicated that people in a position of dependence are relatively more vulnerable to abuse (Mirfin-Veitch et al., 2014).

Whilst anecdotally understood to be commonly experienced by disabled people, there has been little research into this issue in a New Zealand context. It has certainly been highlighted internationally that disabled people are systemically and specifically vulnerable to abuse by people they know and by those who provide care for them (Hague, Thiara, Magowan, & Mullender, 2008; Saxton et al., 2001).

A recent study by Roguski (2013) was commissioned by the Tairāwhiti Community Voice, a collection of community agencies in Gisborne, on the east coast of New Zealand. The research was intended to develop a better understanding of the many ways that abuse is manifested in relation to disabled people. It also aimed to provide a better understanding of the structures that prevent disabled people who were experiencing abuse from speaking out.

The study utilised both a case study and a participatory research methodology with both interviews and focus groups. Participants discussed having experienced abuse in a range of settings, from home to residential services to institutions. Roguski described the frequency of abuse experiences as being driven by pervasive devaluing of disabled people within society (2013). This thesis highlighted abuse of intellectually disabled people in Chapter Eight. Abuse prevention is relevant in the context of developing a support framework that will a) work to integrate a rights framework into rehabilitation for care recipients, and b) employ strategies that undermine power structures that support the abuse of care recipients.

Summary

Literature to date has been identified that informed the current study. Literature reflects that intellectually disabled offenders have been both over-represented in the criminal justice system and not well supported when going through a criminal justice process. Particular complexities are presented by women and Māori who have an intellectual

disability. The need for specialist services and staff in supporting intellectually disabled offenders at every stage through the criminal justice system is reflected in the literature. Diversionary systems that provide an alternative to the usual criminal justice process for intellectually disabled offenders are supported by the literature. The current study explores experiences of the IDCCRA as a diversionary system that is unique to New Zealand.

Also reflected is the importance of rights protection and consideration of community integration issues for intellectually disabled offenders who, as intellectually disabled individuals, occupy a marginal position in society. By using a social constructionist approach, the current research has analysed the context to care recipients' lives and the impact on their subjectivities. No social constructionist research has been completed to date on the IDCCRA.

The literature also indicates the importance of including the views of care recipients themselves in research exploring the IDCCRA. The current study has done this, and the views of care recipients and their service providers are detailed in the following chapters. Chapter Three will analyse the historical, philosophical and policy context of the IDCCRA.

CHAPTER 3 – HISTORICAL AND PHILOSOPHICAL CONTEXT TO THE INTELLECTUAL DISABILITY (COMPULSORY CARE AND REHABILITATION)

ACT 2003

Introduction

The way that people with disabilities have been considered and supported has changed markedly in New Zealand over the last 150 years. These changes reflect both local and international policy developments. Historically, disability was treated as something that was inherently “wrong” with an individual such as a genetic flaw and in need of “fixing”, usually through medical treatment (McHoul & Grace, p. 21).

More recently, significant ideological change occurred within government, policy development and to some degree within the community (Stace, 2010). Rights concepts have come to the fore for disabled people. Government documents such as the New Zealand Disability Strategy (Ministry of Health, 2001a) and the Disability Action Plan (2014) promote the social model discourse of disability, which provides a vision of community integration for disabled people. According to Stace, a New Zealand disability academic, “The social model of disability is quietly transforming us from an exclusionary society into an inclusive one” (Stace, 2010, p. 19).

Examining historical shifts allows for a snapshot of the lives of intellectually disabled people within specific historical contexts. This chapter will provide a broad overview of the historical shifts that occurred in relation the treatment, support and management of people with intellectual disability in New Zealand. Historical shifts in New Zealand in relation to people with intellectual disability have been underpinned by various

social, political, economic and philosophical changes. These have resulted in differences to the way that intellectually disabled people have been both constructed and treated.

History of Support and Management of People with Intellectual Disability in New Zealand

Early Historical ‘Treatment’ of People with Intellectual Disability in New Zealand

Prior to the 1850s in New Zealand, people with intellectual disability were considered the responsibility of their families (Milner, 2008). The positioning of individuals within a family context is congruent with the indigenous Māori culture in New Zealand at the time, which had a world view of collectivism (Tennant, 1996). What followed was a time of increasing European immigration and settlement. Intellectually disabled people, along with other groups such as the poor or mentally unwell, were considered to be a potential burden to society. As such they were not welcome in New Zealand as part of the increasing group of immigrants (Burrell & Trip, 2011).

Shift from Family to State Responsibility

The establishment of a provincial government in New Zealand in the 1850s resulted in a shift of perceived ‘responsibility’ from family and community to the state (Gates, Stewart, Milner, Mirfin-Veitch, & Schumayer, 2008). With limited charitable resources, the perception was that there was a need to control immigration so that these ‘impaired’ individuals did not become a drain on resources (Prebble et al., 2013). In response, the government passed the 1882 Imbecile Passengers Act and the Immigration Restriction Act 1899. Both were intended to prevent certain groups of individuals from entering the country based on their perceived burden (Stace, 2007). The Imbecile Passengers Act required that captains of ships pay a penalty for enabling disabled people to enter the country.

With the provincial government in place, the focus became one of ‘public good’. Intellectually disabled people were not only considered a burden, they were also considered dangerous due to their impairments. The potential impact on the community became the justification for control and containment of these individuals (Milner, 2008). There was also little differentiation between disabled people, the mentally unwell and criminals. All were considered ‘unfit’ (Burrell & Trip, 2011).

Foucault (1977a) noted the development of industrialisation in the 1800s and the development of medicine and sciences during the late 1800s and early 1900s. Following these developments, the perceived need to control certain groups in more systemic and productive ways emerged. With modern medicine came systems of assessment and diagnosis for both people with intellectual disability and mental health problems. The effect was a process of differentiating individuals who had their ‘peculiarities’ and ‘deficiencies’ highlighted. Through this process, certain identities were constructed that supported a process of marginalisation for people with intellectual disability. Once marginalised, individuals become more easily controlled (Burrell & Trip, 2011). Control was provided within an institutional setting (Milner, 2008). By the end of the 1900s a significant number of individuals with disability were being housed in large institutions primarily intended for people with mental health conditions (Gates et al., 2008).

The development of eugenics in the early 1900s also had a significant impact on the treatment of intellectually disabled people, who were considered to have genetic deficiencies. The eugenics movement argued for the control of reproduction to prevent any increase of identified ‘defective’ individuals. Sterilisation was advocated for those who were considered unfit. When the Mental Defectives Act 1911 classified individuals as idiots, imbeciles and feeble-minded, New Zealand had a mechanism for state control (Stace, 2007).

The Act allowed for voluntary admission for mentally unwell ‘patients’ and, with the development of medical services, ‘asylums’ became ‘hospitals’ in the interests of providing more humane and also more medicalised care (Tennant, 1996).

Driven by the eugenics philosophy, intellectually disabled people were constructed as undesirable and dangerous in the early part of the 1900s. Consequently, there was an explicit shift of responsibility from the family to the state for intellectually disabled people. The Education Act 1914 made it compulsory for police, teachers and parents to report ‘mentally defective’ children to the Department of Education (Tennant, 1996). Demonstrating the shift of responsibility from family to state, many children who were considered to be at risk were removed from their family homes. The intellectually disabled person was constructed as in need of removal from their family and isolation from their community for the good of themselves and the community.

The 1924 Committee of Inquiry into Mental Defectives and Sexual Offenders made an explicit link between intellectual disability and sexual offending. Such a link reinforced the need for state control and provided a construction of deviancy for people with intellectual disability. This is noteworthy in light of the current study and the potential stigma created for individuals who are perceived as both criminal and intellectually disabled.

In 1928 the Mental Defectives Amendment Bill, which amended the Mental Defectives Act, allowed for the emergence of institutions primarily for the care of ‘mentally deficient’ children (Gates et al., 2008). Institutionalisation was prompted by moves to separate the ‘mentally ill’ from the ‘mentally deficient’. What followed was the development of a number of psychopaedic institutions in New Zealand. Numbers of people with intellectual disability residing in institutions increased between the 1940s and the 1970s (Gates et al., 2008; Milner, 2008). The purpose of institutions was custodial and intended to

meet basic needs whilst relieving the community and families of the burden of caring for their intellectually disabled family members. In many cases admissions were voluntary until the Mental Health Act in 1969 simplified the process of committing patients to mental hospitals (Burrell & Trip, 2011). Again, the need for state intervention was emphasised.

The Mental Health Act 1969 also supported the strengthening of the medical model, whereby doctors were experts and power holders. Individuals were subjected to a “medical gaze” (Burrell & Trip, 2011, p. 177). Power by clinicians was enacted through the medical assessment, symptoms detection and diagnosis. Many of these ‘patients’, and in particular people with intellectual disability who were considered to have ‘problematic behaviour’, were placed in institutions under the Mental Health Act (1969) (Burrell & Trip, 2011). In line with international developments beginning in the 1950s, New Zealand began a process of deinstitutionalisation.

Deinstitutionalisation

Deinstitutionalisation, which occurred in the latter part of the 20th century for people with intellectual disability, was prompted by a number of factors. The first was a response to the living conditions identified within institutions as not providing a humane level of care (Brunton, 2003). Following a review of psychiatric institutions in New Zealand, the government instituted a moratorium on the expansion of hospitals for both mental health patients and people with disability in 1974 (Milner, 2008). The move towards deinstitutionalisation was also prompted by economic factors and a desire to reduce the costs related to large hospitals (Board of Health, 1987).

The second factor was the developing concepts of normalisation and social role valorisation. Normalisation articulated the idea that people with intellectual disabilities

should be treated the same as any other community member in the interests of equality (Burrell & Trip, 2011). Normalisation “was the term that encompassed many ideals regarding improved conditions for people with mental illness and/or intellectual disability” (Burrell & Trip, 2011, p. 178). It asserted that people with intellectual disabilities should not be segregated from their community. The concept of normalisation had a significant impact on policy and service provision for people with intellectual disability because it was a key driver in the move from institutional care to community care (Walmsley, 2001).

Normalisation has not been without its critics. Normalisation may be problematic for intellectually disabled people who have specific needs (Duff & Sakdalan, 2007). This is particularly so when considering the needs of intellectually disabled *offenders* when faced with a complex legal system that they may not understand. It also fails to recognise the level of vulnerability that many individuals with an intellectual disability have in a prison environment in terms of the usual criminal pathway (Duff & Sakdalan, 2007). One of the challenges for dealing with intellectually disabled offenders is how to draw on elements of the normalisation concept that promote the rights of disabled people to live normal lives whilst ensuring humane care is provided under the IDCCRA.

Alongside the notion of normalisation, the concept of social role valorisation was developed. Begun by Wolfensburger (1983), social role valorisation promoted the idea that integration into the community occurred when value is attached to the roles that individuals have within society. By acknowledging roles such as brother, good listener, reliable worker, great friend, the intellectually disabled person would be seen as having attributes that were worthwhile and a contribution to society. In turn, they would experience feelings of acceptance rather than marginalisation.

The process of deinstitutionalisation was supported by the development of community-based services. The New Zealand government responded to the international movement of deinstitutionalisation in 1985 with a gradual move to community-based services for people with intellectual disability (O'Brien, Thesing, et al., 1999). The last institution for people with intellectual disability, the Kimberly Centre, was closed in 2006, many years after the process of deinstitutionalisation was initiated. According to Milner (2008), the Kimberly Centre was closed some years after the other facilities. Milner claimed the delay was a reflection of the difficulty of transitioning people to the community. However, it is also possible that the transition was delayed due to the perceived difficulty of accepting these individuals into the community.

The development of community residential services for people with an intellectual disability was underpinned by significant ideological change. The change promoted the social model of disability and human rights for people with an intellectual disability (Stace, 2007). The social model provided a philosophical challenge to traditional, medically dominated understandings of disability that constructed individuals as impaired, unwell and in need of treatment (Milner, 2008; O'Brien, Thesing, et al., 1999; Walmsley, 2001).

Legislative Reform: Mental Health (Compulsory Assessment and Treatment) Act 1992

Another element of the deinstitutionalisation movement was the enactment of the Mental Health (Compulsory Assessment and Treatment) Act (MH (CAT) Act) 1992. The MH (CAT) Act 1992 replaced the previous MHA 1969. Importantly, the Act made a distinction between the needs of the mental health population and the intellectual disability population. The Act separated out that which is treatable (mental illness or disorder) from that which is not (intellectual disability) (Dugdale, 2002). Previously, although in many cases housed in separate locations, people with the above conditions were under the one

statute. With the emergence of the social model of disability, it was no longer considered appropriate for individuals with intellectual disability to be dealt with by way of treatment (Brookbanks, 1995).

Introducing the Mental Health Bill to Parliament in 1987, the then Minister of Health noted the legislation would exclude “religious or cultural belief, sexual preference, drug-taking, delinquency, and intellectual handicap” as reasons in isolation for detention in a mental health facility (Duncan, 2013). Accordingly, the power to detain individuals with an intellectual disability due to perceived risk of harm to self or others was not included in the Bill (as it had been under the Mental Health Act 1969).

Section four of the new MH (CAT) Act 1992 reflected the Minister’s policy statement. It excluded a person from being covered by the procedures in the Act “by reason only” of, amongst other things, an “intellectual handicap”. As a consequence, the civil commitment process was not available for people who solely had an intellectual disability; nor did the provisions of the Criminal Justice Act allow for defendants with solely intellectual disability to be detained in a psychiatric hospital instead of being sentenced (Brookbanks, 2003; Duncan, 2013).

Consequently, a group of 37 people with intellectual disability who historically would have been governed (and arguably protected) under the previous Act were released from institutional care and from hospital-level placements into the community. The group were considered to be of risk to themselves and/or others. Most had engaged in sexual offending behaviour, with placement under the Mental Health Act following charges for sexual offending (Brookbanks, 2003).

According to Brookbanks, the change to the new Mental Health Act left only three options for intellectually disabled offenders. The first of these was imprisonment instead of being placed in hospital (Brookbanks, 2003). Various reports indicated that there were significant issues for people with intellectual disability being placed in prison, such as a lack of understanding of the environment and levels of vulnerability to harm from other prisoners. Some of these were canvassed in Chapter Two. It was also claimed that a prison environment did little to address the special needs of intellectually disabled offenders (Brandford, 1997; Ellem, 2010; Hayes, 2006; O'Brien, Miller-Burging, et al., 1999).

The second option involved placement of the intellectually disabled person under the 1992 Act as a mechanism to try and control their antisocial or illegal behaviour. The use of the Act in these instances was problematic and involved a stretching of the scope of the Mental Health Act. In many cases this proved difficult due to the nature of the person's intellectual disability and, as stated above, was not the purpose of the Act (Brookbanks, 2003). A third option was community placement, but this could potentially be problematic if there was inadequate support and strategies to manage any further offending or 'risky' or illegal behaviour (Brookbanks, 2003).

As a result of deinstitutionalisation and the 1992 Act, the number of people with an intellectual disability living in the community increased significantly. This was correlated with an increase in the number of people with intellectual disability coming into contact with the criminal justice system (Brandford, 1997). Australian-based research demonstrated a similar trend (Lindsay et al., 2006).

Public reaction to the release of the 37 identified people with intellectual disability following the 1992 Act was significant (Brookbanks, 2013). As a result, the National government of the time argued that supplementary legislation to the MH (CAT) was needed

(Brookbanks, 2003). This resulted in the 1994 Mental Health (Compulsory Assessment and Treatment) Amendment Bill.

Essentially, the Bill sought to establish a regime of compulsory care for identified intellectually disabled offenders and personality disordered individuals who were considered likely to commit crimes such as sexual offences. The Bill was almost universally criticised as being discriminatory at the select committee stage. A primary concern was that the amendment Bill would establish a new form of preventive detention for people who were considered dangerous based on having an intellectual disability, and the Bill was not passed (Brookbanks, 2003).

The Bill was considered in a report by the Law Commission called *Community Safety: Mental Health and Criminal Justice Issue* (Ministry of Health, 1994). The report examined whether there was a group of individuals for whom the release into the community could cause substantial harm to themselves or others and for whom there was no ability to manage under the current system. The Law Commission noted that people with intellectual disability presented no greater level of risk to the public than those of average intelligence. It was acknowledged that for a small group of individuals presenting with significant risk, there may be a need for legislative reform. A particular focus within the reform was on the disposition of sexual offenders: “Given that neither mental health nor criminal justice legislation is applicable or appropriate for all intellectually handicapped people who are dangerous, there is a threat to community safety arising from the lack of any appropriate legislative protection” (Ministry of Health, p. 44).

Based on this consideration, the Commission stated that amendments to the 1992 legislation were not appropriate, and it recommended “creating a specific legislative regime for offenders, alleged offenders, and non-offenders who are intellectually handicapped and

whose behaviour poses a significant risk for others” (Ministry of Health, p. 45). This demonstrated that the construction of intellectually disabled offenders as dangerous and posing danger to society was fundamental to the decision for legislation reform.

The Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003

Policy Context to the IDCCRA

In response to the report in December 1995, the Ministry of Health commissioned a background paper titled *The most appropriate way to address issues raised with the care of people who, because of the intellectual disability, present a serious risk to others* (Brookbanks, 1995, p. 2).

The paper suggested that there should be legislation developed for intellectually disabled offenders that accorded them the same degree of protection as provided to mental health consumers by the Mental Health Act 1992. Separate legislation was considered appropriate based on socially constructed differences between the needs of mental health consumers and intellectually disabled people.

According to Brookbanks (1995), “such legislation would aim to protect the rights of the target group and ensure their safe and appropriate care when it is justified” (p. 536). The discussion paper recommended that only those who were perceived to be most at risk of offending should be targeted and that any model of care should be separate from that provided under mental health. Again, these were considered to be largely those who had committed sexual offences. A stand-alone legislative regime was recommended that would provide a specific legal and service provision framework to meet the unique needs of intellectually disabled offenders (Brookbanks, 1995, 2003, 2013).

In March 1996 the Ministry of Health released a report titled *Report of the Ministry of Health on Submissions received in Response to a Discussion Paper by Warren Brookbanks on the Development of Legislation to meet the needs of individuals with intellectual disability who, because of their disability, are considered to present a serious risk to others* (Cotter, 1996). A total of 34 submissions were made by individuals and by advocacy, health and legal groups. The submissions indicated general acceptance of the direction detailed by the paper and support for the idea of stand-alone legislation. Concerns were cited relating to whether non-offenders or those at risk of offending would be included. Concerns were also raised regarding the need for workforce development and whether there would be adequate resources to support their development (Cotter, 1996).

In May 1996 a further position paper titled *Proposed legislation to facilitate the compulsory assessment, care and support of persons with intellectual disability: A position paper* was released by the Ministry of Health (1996). The position paper detailed a “broad outline of procedures and safeguards to meet the needs of those individuals with intellectual disability whose behaviour presents a serious risk to themselves or to others and who may require compulsory assessment, care and habilitative support” (1996, p. 4).

The position paper identified the previously established support for a stand-alone legislation. However, it also identified a lack of information regarding numbers of people with intellectual disability posing a serious danger to themselves or others (1996). Although 37 individuals had been released from psychiatric hospitals following the Mental Health Act in 1992, the extent of the problem was unknown and this point was largely based on community fears.

The position paper also detailed principles that would be set out in the legislation that related to the rights of care recipients under the New Zealand Code of Health and

Disability Services Consumers' Rights 1996 and were also consistent with international human rights obligations. In respect of these two principles, the paper proposed that "people should be subject to the least restrictive legal framework and should always be treated in the least restrictive environment conducive to their specific needs" (1996, p. 5).

This is not a new concept and has been previously described as the 'least restrictive environment'. It became a core principle in the early days of deinstitutionalisation with the development of services outside the institutional environment. As described by Taylor, "LRE emerged in the 1960s when leaders in the field began to advocate for the development of a range of special education placements for students with disabilities" (1988, p. 219). Detailed was a continuum of services from the most restrictive to the least restrictive setting depending on need. As described by Turnbull, "government (or person, family, or professional) presumes that there is a generally accepted hierarchy of placements, treatments, or interventions and that any given one is clearly rank ordered as more or less restrictive" (Turnbull, Ellis, Boggs, Brookes, & Biklen, 1981, p. 17). The concept of least restrictive options is based on the rights of intellectually disabled people to live with the least restriction possible, with the government pursuing the management of individuals in a manner that "least intrudes or infringes upon individual rights" (Taylor, 1988, p. 219).

Also stated was that the legislation should be based "upon appropriate philosophy, concepts, models, skills and services from the field of disability" (Ministry of Health, 1996, p. 5). This philosophy was enacted in the later decision taken by the government to engage disability providers to provide services to care recipients under the legislative framework. What I have termed an intellectual disability discourse will be discussed in detail in Chapter Five. It is important to note that the influence of an intellectual disability discourse, which constructs people living with intellectual disability as permanently impaired and child-like,

is evident in the legislation. I suggest that the government made a very deliberate decision to utilise a disability support framework with an assumption that the model of care would be based on meeting disability support needs.

Later that year the Ministry of Health identified the need to establish some understanding of the potential numbers and cost estimated for the group of intellectually disabled offenders who could become subject to the new legislation. The Ministry of Health commissioned a:

...survey of all providers of services to people who have intellectual disabilities, in order to: discover where these “*dangerous people*” are located, the nature of the behaviours that were perceived as being ‘seriously dangerous’, the perceived ‘degree’ of the perceived ‘dangerousness’, the nature of the services that currently support them, and an indication of desirable support services for them. (Webb & Capie, 1996, p. 3) (*Italics in original*).

The results predicted that around 200 people qualified, mostly men aged between 25 and 40 years, who were at risk of violence to themselves and others. Only a small number of individuals presenting with risk of a sexual nature were subsequently identified in this report. This was in contrast to the public perception of these individuals likely being sexual offenders based on the nature of offending engaged in by the original 37 individuals who were released into the community (Webb & Capie, 1996). Other key themes in the report included a clear preference for community-based services and the provision of specialist behaviour support implemented by service providers. This was consistent with the deinstitutionalisation process and shift from the medical discourse, with treatment provided by professionally trained staff, to a social model discourse.

In 1997 a further report was sought by the Ministry of Health from John Dawson, a legal academic at the University of Otago in New Zealand. The purpose was to provide an analysis of any risks and/or benefits arising from the proposed legislation and to determine whether the legislation should include those who were considered ‘at risk’ of offending but not formally charged (Dawson, 1997). In contrast to the previous reports described above that had a focus on ‘challenging behaviour’, Dawson described the proposed legislation as a ‘forensic model of compulsory care legislation’ (Dawson, 1997, p. 6).

Dawson did not advocate for a civil commitment regime but proposed a model that could include greater use of the Protection of Personal and Property Rights Act 1988, which allows for a court-appointed ‘welfare guardian’. He also posed additional elements to customary criminal options for the court, such as probation with the addition of a care plan.

In contrast to previous reports, Dawson emphasised the need for significant service development and stated that current disposition options for intellectually disabled offenders, such as community probation, were often limited by the absence of services. According to Dawson, “the shape of the legislation itself depends to some extent on service development issues” (Dawson, 1997, p. 8).

The issue of resourcing was clearly identified in the early stages of development of the IDCCRA. In an early consultation paper, Dawson stated the following:

In my view, the service questions cannot be put to one side, to be resolved later through contractual arrangements. The shape of the legislation itself depends to some extent on service development issues. It is not sufficient for a statute of this kind to refer simply to ‘appropriate facilities’ and ‘appropriately qualified professionals’.

Compulsory care of vulnerable people in secure conditions for long periods of time

is contemplated. Adequate standards of care and protection of the basic human rights of detained people must be assured by the state; and people with intellectual disability should not be effectively imprisoned under court orders in inadequately monitored environments (Dawson, 1997, p. 8).

The same concerns were mooted throughout the Parliamentary debates prior to and during the final reading. The following by Sue Bradford MP reflects the many comments that were made in regard to resourcing:

The major concern the Green Party has with the legislation is not with its intent but with its implementation, as the previous speaker also pointed out. We are suspicious that the number of secure placements needed for offenders covered by the bill's provisions will not be enough — either now or in the future. I hope that the ...Government will continue to commit sufficient funding as the agencies go along to make sure that that happens. (Bradford, 2003, p. 9564).

Dawson (1997) identified three distinct groups of individuals as needing consideration in terms of the development of new legislation. The first group was described as unlikely to have been included in the Capie and Webb (1996) survey due to this group of people having had limited access to disability services. He described them as:

...seriously socially disabled, often due to deprivation in childhood. They are difficult to handle within the criminal and penal systems. They may be illiterate, impulsive, unreliable, in poor physical health, and with further problems associated with substance abuse or institutionalisation. (Dawson, 1997, p. 9).

As identified in the literature in Chapter Two, some intellectually disabled offenders present with similar characteristics to mainstream offenders in relation to the issues

identified by Dawson (1997). This group will have had limited access to disability support services for a range of reasons. Dawson perceived this group as likely to come to the attention of court staff. He also considered such offenders would benefit from non-custodial criminal sentences, with the proviso that they would remain the combined responsibility of probation *and* disability service providers. Dawson noted the social and environmental context for this group, who are seen as criminal as a result of their background and not directly because of their intellectual disability.

Also identified was a second group with mild to moderate intellectual disability who were “assaultative, sexually inappropriate, abusive, destructive of property or harm themselves repeatedly” (Dawson, 1997, p. 10). Dawson noted that the level of impairment that these individuals experienced was related to their offending and their potential for rehabilitation was therefore limited. Dawson stated that this group had limited responsibility due to their level of disability. He also saw them in need of protection from abuse. He did not view this group as being appropriately covered by the proposed legislation but instead saw them coming under an alternate protective legal mechanism. However, he did not describe the alternative in detail.

The third group Dawson described as individuals with a mild or moderate intellectual disability who had committed serious, imprisonable offences. In his view, this group met the intended scope of the legislation in terms of requiring an alternative to a prison sentence. He argued that whilst a range of disposition options should be available for this group, the appropriate place for this to happen was within intellectual disability services, sometimes in secure care. These were offenders who had intellectual disability and were considered capable of understanding and being held responsible for their crimes. They were also considered capable of engaging in a rehabilitation process. Dawson stated that “the

compulsory care regime should be carefully limited to this third group” (Dawson, 1997, p. 12). Again, the intellectual disability is highlighted and may, in fact, have led to the engagement of disability service providers.

The Passing of the IDCCRA

The Intellectual Disability (Compulsory Care) Bill was introduced to the House in October 1999 by Georgina te Heuheu, the Associate Minister of Health. Te Heuheu detailed four reasons for the introduction of the Bill: the exclusion of intellectual disability without a coexisting mental health condition from the MH (CAT) Act 1992 concerns regarding the options of care available for intellectual disabled offenders concerns regarding a small number of dangerous individuals, and the rights of the community to safety and protection (Te-HeuHeu, 1999, p. 19695).

The intention of the original Bill was to provide a unique legislative pathway for dangerous intellectually disabled individuals. It was proposed for both offenders and those who had been charged with an imprisonable offence in addition to those termed non-offenders or civil individuals who were considered dangerous and at risk of offending (Mundell, undated). The inclusion of the non-offender group was consistent with the recommendations in the earlier New Zealand Law Commission report and within the scope of what was detailed in the Dawson 1997 report. Each group would be dealt with in separate sections of the Act.

The Bill was then considered by the Health Select Committee, which received submissions from a number of different organisations including the Human Rights Commission and the National Assembly for People with Disabilities, which opposed the civil entry pathway on the basis of human rights. A civil entry pathway refers to the ability

for individuals to be placed under the Act prior to entry into a criminal justice pathway. The question was why someone with an intellectual disability should be treated any differently to others in respect of compulsory care in the absence of criminal charges.

Concerns were also raised by organisations such as Intellectually Handicapped Children (IHC) regarding the potential for the Act to become a “back-door method of re-institutionalising people with intellectual disabilities” (Dyson, 1999, p. 19697). Perceived risk was not considered justification for legal commitment by the submitters. The civil route was removed prior to the Bill being referred back to the House of Representatives for its third reading in October 2003 (Brookbanks, 2003; Dugdale, 2002; Duncan, 2013).

Two other changes occurred following the Select Committee stage. Firstly, the term ‘intellectual disability’ became more clearly defined (Duncan, 2013). Intellectual disability was defined as including three factors: an intelligence quotient of 70 or below with a standard error of plus or minus five and a confidence level of not less than 95%, evident during the developmental period of less than eighteen years and evidence of significant impairment in relation to adaptive functioning such as social skills, safety and skills of daily living (Duncan, 2013).

Secondly, the Bill initially titled ‘The Intellectual Disability Compulsory Care Bill’ became ‘The Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003’. Rehabilitation was included in the title to ensure that services had a clear focus on improving the functioning and decreasing the dependency of individuals held under this Act and that care provided was not only custodial in nature but also provided a meaningful outcome in terms of rehabilitation (Duncan, 2013).

The inclusion of the word rehabilitation was extensively debated in Parliament on the basis of two issues. The first was the lack of definition provided for rehabilitation.

Heather Roy MP stated the following:

I think rehabilitation is a word that is often misunderstood, and that in this case we are asking for trouble, in a way, by including it in the title. I would have thought that with its inclusion in the title it should, perhaps, have been defined. That would have made a good deal of sense. It should have been defined so that we know exactly what it is. (Roy, 2003, p. 9571)

The other issue was whether individuals with an intellectual disability were in fact able to be rehabilitated, based on a notion of their disability and level of functioning being fixed over a lifespan. This was exemplified in a statement made by Sandra Goudie MP:

As I look at the title Intellectual Disability (Compulsory Care and Rehabilitation) Bill, I think: what about making it the Intellectual Disability (Compulsory Care and Rehabilitation or Not) Bill? Rehabilitation is not absolutely always something that can be achieved. I would like to acknowledge our concerns about rehabilitation not being defined. I think definition is absolutely necessary. (Goudie, 2003, p. 9572).

One concern that was raised during the Select Committee stage that did not result in a change was that compulsory care orders could be extended for longer periods of time than the original term of the compulsory care order (Ministry of Health, 2001b). The Mental Health Commission raised concerns that the ability to extend orders could equate to ‘indefinite preventative detention’ (Ministry of Health, 2001b, pp. 18-19). It was considered that the Bill included legal safeguards such as the Family Court ordering the release of individuals should ongoing detention be deemed unnecessary, and the administration of six-

monthly reviews. In addition, the Crown Law office examined the Bill and established that it was not in breach of the New Zealand Bill of Rights Act 1990.

Following a report back to the House of Representatives by the Health Committee, the reviewed purposes were presented in the third reading as follows:

- To provide courts with appropriate compulsory care and rehabilitation options for people who have an intellectual disability and are charged with, or convicted of, an imprisonable offence
 - To recognise or safeguard the special rights of people subject to the Act
 - To provide for the appropriate use of different levels of care for individuals who, while no longer subject to the criminal justice system, remain subject to this Act.
- (O'Connor, 2003, p. 9558).

Like the MH (CAT) Act 1992, the IDCCRA limited certain rights in the interest of managing risk, such as the right to freedom of movement and the right to refuse medical treatment. The Act included statutory powers to allow for the use of seclusion within a hospital environment and to restrain and medicate within defined situations. These restrictions were balanced against rights and safeguards. Protection of the rights of care recipients is stated as a purpose of the Act. Principles governing exercise of powers under this Act specify the following:

Every court or person who exercises, or proposes to exercise, a power under this Act in respect of a care recipient must be guided by the principle that the care recipient should be treated so as to protect—

- (a) the health and safety of the care recipient and of others; and

(b) the rights of the care recipient (Intellectual Disability (Compulsory Care and Rehabilitation) Act, 2003). As previously mentioned in this chapter, the underlying philosophy of least restrictive option should guide how care recipients progress through a continuum of services with increasing levels of freedom.

The Act suffered a seven-year gestation period. Whilst a separate legislative pathway for intellectually disabled offenders was largely supported by policymakers, the legal profession and the public, there had also been criticism of a disability-based diversionary system both during the development and the implementation of the Act. Some argued that the separate legislation and the amount of resources required for a small number of people were not justified (DuFresne, 2008).

The Act's passage provided new and alternative options for people with intellectual disability who were charged with imprisonable offences. It also allowed for those who were currently in prison, or who were currently or previously in compulsory care under a special patient status, to come under a compulsory care order. This was a unique decision on the part of the New Zealand government and the only one of its kind.

The Operation of the IDCCRA

Referral Pathways

The purpose of the IDCCRA was to provide alternative options for individuals with an intellectual disability who were charged with or convicted of an imprisonable offence (Ministry of Health, 2004). The Act allowed for three modes of entry. The first was by referral from the court during criminal proceedings, with compulsory care provided as an alternative to a prison sentence. The second mode of entry was by transfer from prison. Due to the reasonably lengthy time the Bill had taken to progress through Parliament, it was

thought that there would have been a number of intellectually disabled offenders who had been imprisoned during this time. The transfer provisions allowed for these individuals to come under the IDCCRA. It also allowed for those who had not been identified during the criminal proceeding to be identified during their prison sentence as having an intellectual disability and be transferred to the IDCCRA where appropriate. ‘Appropriate’ circumstances related to issues such as risk and the ability to engage in a rehabilitative process. The third mode of entry allowed for those who were placed under the MH (CAT) Act as special patients prior to the enactment of the IDCCRA to be transferred under the new legislation (Duncan, 2013; Ministry of Health, 2004).

Statutory Roles under the IDCCRA

The Act provided a number of statutory roles that were designated by the Director General of Health or by the compulsory care coordinator to provide functions detailed in the Act.

Compulsory Care Coordinators are designated to administer the IDCCRA. Care coordinators usually come from a health professional background. They facilitate many of the processes detailed in the Act and provide a central point of contact for the care recipient. They are employed by the National Intellectual Disability Care Agency, which provides needs assessment and service coordination to both care recipients and ‘civil’ clients under the High and Complex Framework (Ministry of Health). Civil clients are those who are not under compulsory care but received support under the high and complex framework due to their level of risk of offending. Specific duties of the care coordinator include the following:

- processing applications for compulsory care orders and organising assessments

- ensuring needs assessments are carried out and care and rehabilitation plans are developed
- applying for court orders for compulsory care
- liaising with the court and providing reports regarding changes to compulsory care orders
- designating care managers
- receiving (and in appropriate cases acting on) reports made by district inspectors (Ministry of Health, 2004).

Care Managers are designated by the care coordinator to develop and implement the care and rehabilitation plan. Care managers are usually from a health professional or disability background. They are legally responsible for the custody of care recipients. They are also responsible for ensuring that six-monthly reviews of care recipients' care and rehabilitation plans occurred. Care managers have additional powers such as to seclude and restrain, grant leave for care recipients and to retake care recipients who are absent without leave (Ministry of Health, 2004).

Specialist Assessors are psychologists designated for the purposes of providing assessments regarding intellectual disability, risk assessments and recommendations regarding levels of care. They also complete six-monthly reviews for care recipients.

District Inspectors are lawyers who are currently appointed under the MH (CAT) Act to ensure that mental health consumers' rights are upheld as they progress through the MH (CAT) Act 1992. They provide a similar function under the IDCCRA. District Inspectors provide an independent monitoring function to ensure that care recipients have their rights

upheld. Their role is also to investigate and report any breaches of rights as specified in Part 7 of the IDCCRA (Intellectual Disability (Compulsory Care and Rehabilitation) Act, 2003).

Medical Consultants are medical practitioners who provide a second opinion on whether an individual should receive medication for the purpose of managing their condition. Their second opinion is to safeguard the care recipient from medication being used inappropriately in terms of behaviour management.

Roles such as the District Inspectors and medical consultants ensure that care recipients' rights as specified in the Act are upheld and safeguards provided. Additionally, care recipients are identified as consumers under the Code of Health and Disability Services Consumers' Rights, with corresponding protections (Ministry of Health, 2004).

Provision of Care and Rehabilitation

The purpose of the IDCCRA is to provide care and rehabilitation. Following a recent Court of Appeal case, rehabilitation is taken to mean "Improvement of the character, skills and behaviour of an offender through training, counselling, education etc. in order to aid reintegration into society" (NZCA, 2011). The Court of Appeal case also made comment regarding the Health Select Committee having specified the need to recognise rehabilitation provided under the IDCCRA and referred to the following section in the Health Select Committee report (2001):

We believe there should be explicit recognition of the importance of rehabilitation, where possible to ensure that people do not receive custodial care only. It is important to assist care recipients to develop the range of skills they need to manage difficulties in their lives in structured programmes. These programmes should be tailored to the needs of each client. For some there will be fluctuations among

different levels of care. For each there will be options for the appropriate level of supervision and security to avoid danger to the health and safety of others. (p. 7).

To support the implementation of care and rehabilitation under the IDCCRA, the Ministry of Health contracts a number of specialist support services, such as sexual offender treatment programmes, life skills and day activities programmes and clinical community services. Currently, two national units based on forensic hospital sites are provided in Auckland and Wellington with twelve beds and ten beds respectively (Ministry of Health).

The National Intellectual Disability Care Agency (NIDCA) provides needs assessment and service coordination for individual clients under the framework. Services are provided to both care recipients and NIDCA civil clients. NIDCA civil clients are individuals with an intellectual disability whose high and complex behavioural needs are too great to be adequately supported within mainstream services. NIDCA employs the care coordinators (Ministry of Health).

Categories of Care Recipients

The Act allows for two categories of care recipient. The first is special care recipients, who must always receive care and rehabilitation in a secure facility. In most cases, special care recipients receive their care in a hospital-level service. The second category is care recipients who may receive care and rehabilitation in a secure or a supervised setting (Duncan, 2013; Ministry of Health, 2004). For the purposes of the current study, care recipients who reside in the community have been the primary focus due to their coming to the end of or having recently ended their compulsory care.

For care recipients who do not have special status, the IDCCRA provides for two different kinds of orders: secure and supervised. The level of order reflects both the level of

offending and the level of ongoing risk. The level of order made by the court has a direct impact on the level of service provided to the care recipient.

The Regional Intellectual Disability Secure Services (RIDSS) and Regional Intellectual Disability Supported Accommodation Services (RIDSAS) provide hospital-level and community-level placements respectively. At the hospital level, services are provided by regional forensic psychiatry services, and care recipients are housed in specialist units alongside forensic mental health units. Only care recipients under a secure order can be placed in hospital-level services. Community Liaison Services are also contracted to provide specialist consultation and liaison for care recipients in the community (Ministry of Health).

Secure orders require twenty-four-hour observation and the ability to provide two-to-one level of staffing where required. Restrictive practices include restraint and seclusion (in hospital-level services only) where appropriate. A multidisciplinary approach and regular reviews are also required. Environmental features include locked doors, unbreakable glass windows, building design that allow for constant observation from staff, alarm systems and perimeter fencing. These features are required in both hospital and community secure settings (Ministry of Health, 2006). Care recipients in secure services are positioned as being dangerous and in need of a greater level of control.

Community placements are provided by RIDSAS, which is an established disability provider (Duncan, 2013). RIDSAS provides support to individuals under both secure and supervised orders. The decision regarding whether a secure order is delivered in the community or hospital is largely based on risk and decided by the care coordinator in consultation with others. Community secure services are largely for secure-care recipients and provide the security features detailed above.

Care recipients under supervised orders are given a greater level of freedom and flexibility and, in the main, do not reside in community secure placements. Supervised care recipients are usually offenders who commit less serious offences, are considered to pose less risk or are near the end of their period of compulsory care. The greater level of freedom provided under supervised care is considered to prepare individuals for the transition back to the community.

As noted by Duncan (2013), the Ministry of Health is currently developing a new model of care and rehabilitation for care recipients. He predicted there will be a particular focus on those young people who have been identified as an emerging group under the framework:

Many NCRs (new care recipients) have been victims of abuse or neglect, and have becomes CRs (care recipients) in their teens and disproportionate are Māori. These factors mean that, to be useful, the developed model must be able [to] facilitate the psychological and cultural development of all members of this marginalised group. (Duncan, 2013, p. 369).

The new model of care and rehabilitation will be explored briefly in Chapter Eight in terms of the findings of the current research. As reflected in the literature in Chapter Two, Māori are overrepresented under IDCCRA. The provision of cultural assessment under the IDCCRA framework is an attempt to address the specific needs of Māori.

Cultural Assessment

Section 23 (1) of the IDCCRA 2003, titled ‘cultural assessment’, specifies that the care coordinator must “identify the care recipient’s culture, ethnicity, language and any religious or ethical beliefs” (Intellectual Disability (Compulsory Care and Rehabilitation)

Act, 2003). Following this, Section 23 (2) states if “the coordinator considers that the care recipient is Māori and the care recipient agrees with that assessment, the coordinator must try to obtain the views of any suitable Māori person or Māori organisation concerned with, or interested in, the care of persons who have an intellectual disability” (Intellectual Disability (Compulsory Care and Rehabilitation) Act, 2003).

A Guideline has been developed by the Ministry of Health to support the implementation of cultural assessment for care recipients (Ministry of Health, 2003a):

The Ministry of Health has identified the need for a set of guidelines on the process of assessment of Māori and subsequent care planning process, which is designed to be effective, efficient and appropriate for Māori and their whanau as part of the assessment process under the IDCCR Act. (2003a, p. 1).

The purpose of the guideline was to provide a robust cultural assessment process to potential care recipients who were Māori. This was to ensure that their cultural needs were both recognised and met through the care and rehabilitation process.

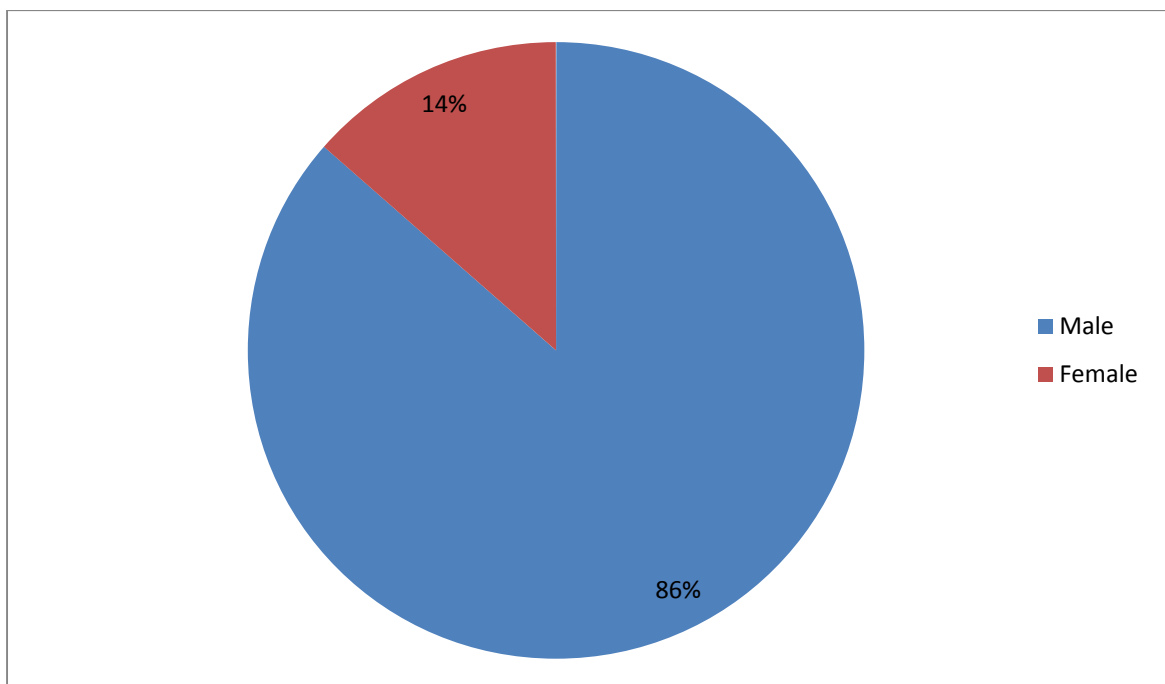
Demographics

The following graphs provide current demographics for the care recipient population as at the end of December 2014. Graph One shows the gender of care recipients, with 86% male and 14% female respectively. This is consistent with the international literature that demonstrated that female offenders were a minority in both mainstream and care recipient groups (Hayes, 2007b). Again, as reflected in the literature, Māori are overrepresented under the IDCCRA framework, with a figure of 38% (see Graph Two). The age of care recipients reflects 6% being under the age of 18 years (see Graph Three). Graph Four shows the

number of secure and supervised orders for the 2014 year, with 32 orders made and 7 subsequent orders.

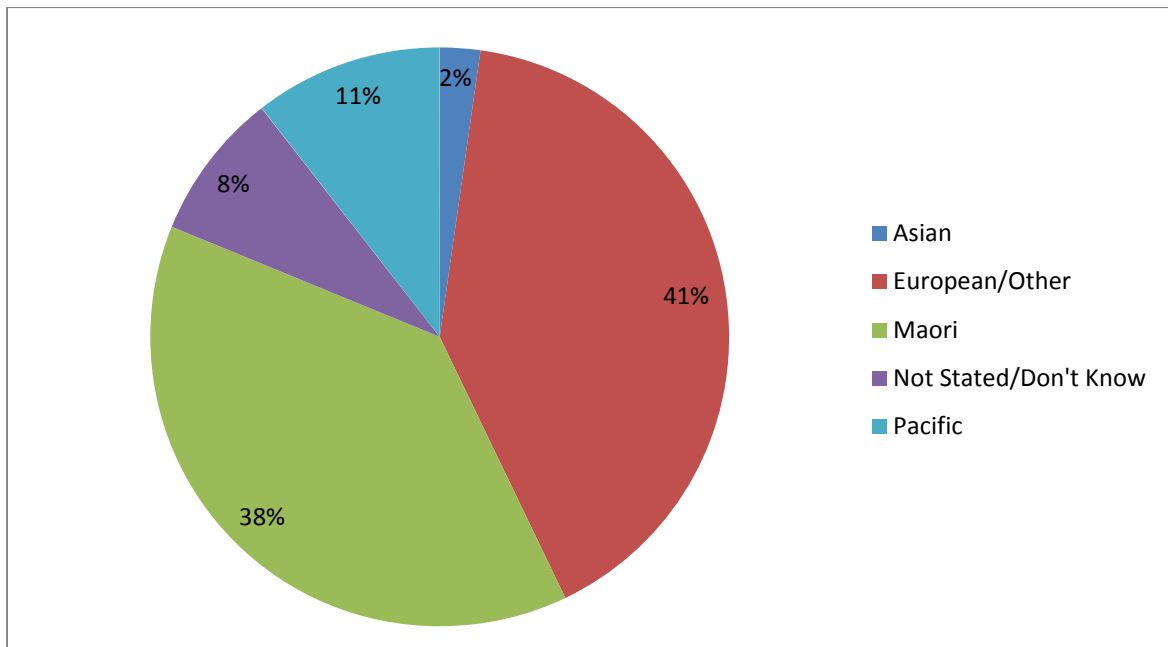
Graph One

Gender of People under Compulsory Care as at December 2014



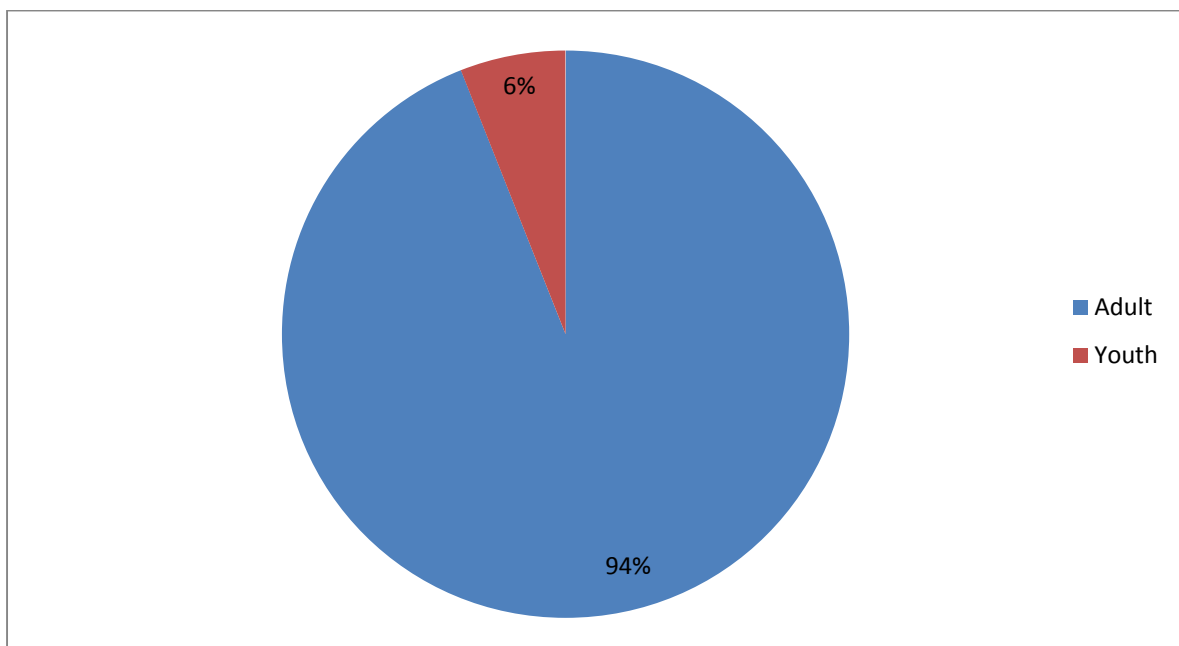
Graph Two

Ethnicity of People under Compulsory Care as at December 2014

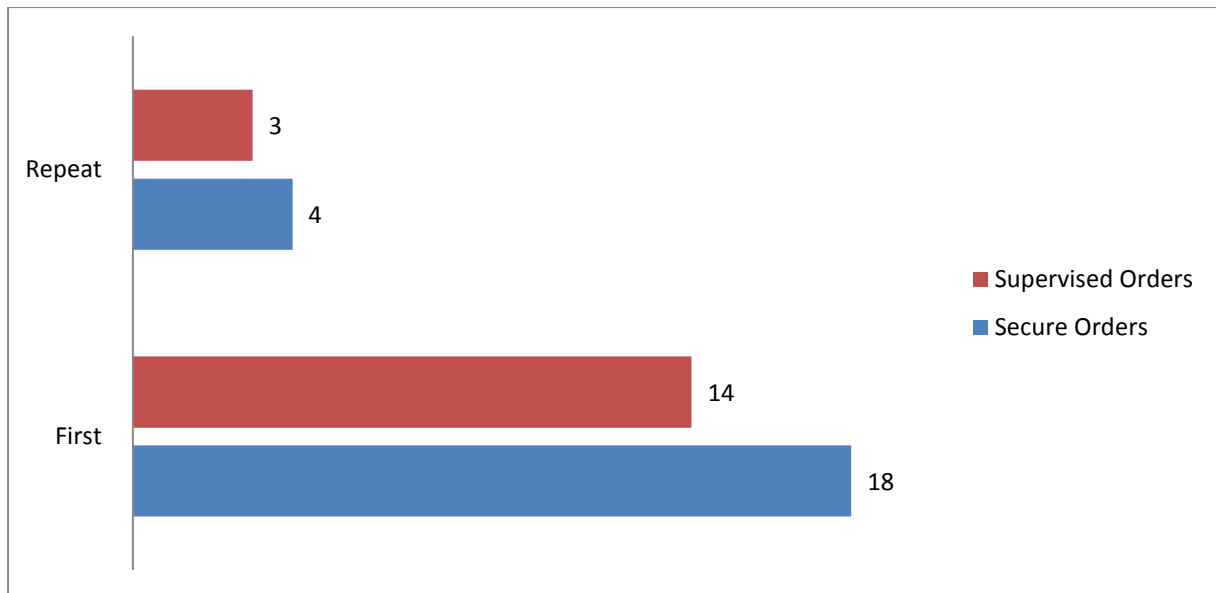


Graph 3

Age of People under Compulsory Care as at December 2014



Graph 4

Orders this Calendar Year (2014)

Summary

This chapter detailed the philosophical shifts that impacted on the support and management of intellectually disabled people in New Zealand over the 19th and 20th centuries. The analysis allows an understanding of the historical context and development of services that led to the passing of the IDCCRA 2003. A description of the IDCCRA and the processes and structures it sets in place has been given. Chapter Four will detail the methodology used for this study.

CHAPTER 4 - METHODOLOGY

Introduction

This research examined the discourses deployed by persons who have become subject to the IDCCRA as described by the care recipients themselves and service providers who were involved in their lives. The chosen methodological approach of social constructionism was considered most appropriate for the aims of the research and the specific questions being asked. This chapter describes the key philosophical concepts of post-structuralism and social constructionism and how these shaped the research process. The key concepts used in this study are defined. Each step of the research process is illustrated, including participant selection, data collection, data analysis, and the ethical considerations and process undertaken. The social constructionist process of discourse analysis is described in terms of the process by which discourses were defined and analysed for this study in terms of how discourses shaped the experiences narrated by care recipients and people involved in supporting them.

This discourse analysis is underpinned by a social constructionist orientation to knowledge. Rather than being a method, social constructionist discourse analysis provides a broad framework regarding the influence of discourses both in language and the wider social and political arena (Burr, 2003). Rather than establishing an observable truth, discourse analysis has a focus on the social and political context within which meaning is produced.

The current research involved a close examination of texts; specifically, the transcripts of interviews with care recipients and people who worked with them and of the sections of the Hansard records of the parliamentary debates that occurred at the time of the second and third readings of the proposed Act. This served to establish meaning, claimed

within a specific cultural, social and historical context. The analysis involved delving below the surface and attempting to deconstruct the meaning within.

Theoretical framework

A qualitative paradigm was chosen for this research as the most appropriate to explore the individual perspectives of care recipients and their support people. The decision to use quantitative or qualitative methods is loaded with assumptions about the nature of knowledge and reality (Giddings & Grant, 2002), how we understand knowledge and reality, and the process of acquiring knowledge about reality (Creswell, 1994). All such assumptions guide the research in a particular way from the methodology used to the questions asked of participants.

The particular philosophical perspective which underpins the current study is post-structuralism. A social constructionist methodology is utilised. Based on the notion that the world we live in is socially constructed (Burr, 1995; Cheek, 2000; Crotty, 1998; Giddings & Grant, 2002), discourses were identified as deployed by individuals subject to the IDCCRA both prior to and following release. The reason for the focus on this period of time was to explore the systems and processes that occurred near the time of potential release. Examining discourses that care recipients and service providers have drawn on and become subject to allowed a more in-depth understanding of the multiplicity of meanings that shaped their realities.

Post-structuralism

Post-structuralism contrasts with positivism by providing an understanding of objects as being both socially constructed and specific to place and time (Wetherell, Taylor, & Yates, 2001b). Positivism, in contrast, offers meaning that is based on a 'truth' that is predictable

and controllable using scientific knowledge (Smith, Booth, & Zalewski, 1996). Post-structuralism as a philosophical theory was developed in the latter part of the 20th century by theorists such as Derrida, Foucault and Kristeva, and in some cases was an overt rejection of structuralism (Cheek, 2000; Pardeck, Murphy, & Choi, 1994).

Traditionally, language has been viewed mainly as an expression of our thoughts and feelings and a way to communicate shared understandings of things in our world. According to post-structuralism, any understanding of the world around us that we have is specific to and influenced by the language used in a number of different social, cultural and material contexts. Rather than language providing a means to universalise both objects and individuals, multiple meanings become possible depending on these contexts. As a result, post-structuralism provides findings that are specific to a context and unable to be generalised. Thus uncertainty and ambiguity are fostered (Burr, 2003; Gavey, 1989, 2011). This means that multiple truths are possible in any given situation.

A modernist understanding of identity asserts that people have an essential nature that can be discovered and is demonstrated through individual personality (Gavey, 1989). In contrast, post-structuralism seeks to expose the ways in which language both constitutes and is constituted by our experiences, not only mediating our understanding of the world but also shaping our experiences. In this way individuals and experiences become discursively constructed and understood (Burr, 2003). Through language, multiple truths and realities were conveyed. In this research a post-structural lens allowed an exploration of the ways in which language or the words that were used by care recipients and service providers reveal the discourses and discursive practices in play.

Social Constructionism

Social constructionism is a collection of theories that have a common thread relating to knowledge and reality. According to Burr (2003), there are four key requirements that are common to a social constructionist orientation to knowledge. The first is that taken-for-granted knowledge must be viewed with a critical eye. Shared understandings that exist about the world should never be accepted at face value and should always be questioned to expose what lies beneath.

In direct contrast to positivism, social constructionists problematise the notion that the nature of the world will be revealed through observation and measurement alone (Burr, 2003). For example, there are a number of assumptions that are made about people with intellectual disabilities in terms of taken-for-granted knowledge. This will likely include assumptions regarding an inability to fully function within society and having a number of 'impairments' and 'risks' (Munford & Sullivan, 1997). A social constructionist view would require that such assumptions are questioned and that further exploration is conducted to 'critique' these assumptions.

The second requirement of social constructionism is that knowledge is always located within a specific social, historical and cultural context. Therefore, when analysing the stories of care recipients, a social constructionist framework provides the opportunity to examine situations within their New Zealand historic, cultural and social contexts and analyse the ways in which these situations create power dynamics that may ultimately disadvantage those individuals (Burr, 2003).

In this study, two key periods in the history of the IDCCRA were considered. The first was from the time that the new legislation was being considered on a policy level by the

Ministry of Health in 1995 to the time of it being passed through Parliament as the IDCCRA 2003. The parliamentary debates were utilised as data with a reading of Hansards (a record of proceedings in Parliament) from the second and third readings of the Bill prior to being made an Act. The second period of time was seven years following the passing of the IDCCRA, in 2010, with the words of the participants being utilised as data.

The third requirement articulated by Burr (2003) is that a social constructionist version of the world is firmly located within the social realm; it is through our interactions with others that our versions of knowledge become developed and are sustained (Dean, 1993). Language provides a means to examine the ways in which individuals are constructed. It is well understood that the words we use to describe each other are laden with meaning and serve to marginalise people with disabilities (Goodley, 2011). In a society that is slowly becoming more inclusive, derogatory language is becoming far less acceptable. It is not so long ago that words such as ‘retarded’ and ‘spastic’ were commonplace to describe people with intellectual disabilities. The term intellectual disability is utilised in this study as a reflection of the specific term and associated meaning provided by the IDCCRA. However, it is recognised that for some, having this label and diagnosis may provide a “powerful and stigmatising identity” (Beart, Hardy, & Buchan, 2005, p. 47), indicating the significance of language in terms of experience for care recipients.

The fourth requirement posits that in any social interaction there are a number of possible ‘constructions’ of the world. Every construction provides limits to what we can say and do in any given situation, therefore providing limits to our understanding of an individual (Burr, 2003). This is demonstrated in this research, where multiple subjectivities are drawn upon for individuals who are considered ‘criminal’, ‘intellectually disabled’, ‘community members’ and a number of other subjectivities. Social constructionism draws on Foucault’s

(1977a) notion of discourse as a means to construct individuals in terms of subjectivity and power relationships.

Discourse

Discourse can be described as ‘patterns of meaning’ (Parker, 1999, p. 3) that are played out within language, practice and societal structures (Burr, 2003; Gavey, 1989; Parker, 1999). In any given situation, multiple discourses influence how we see others and ourselves, provide limits to our conduct and make a number of ‘truth’ claims.

Discourse analysis is underpinned by a social constructionist orientation to knowledge. Rather than establishing an observable truth, discourse analysis has a focus on the social and political context within which meaning is produced. Each discourse constructs individuals in a particular way. Different discourses may contradict, interact and clash with one another, resulting in a fragmented and contradictory subjectivity for the individual (Burr, 2003).

As described by Foucault (1972), discourses are “practices that systematically form the objects of which they speak” (p. 49). In this way discursive objects are created, as are particular speaking positions, subjectivities, practices and power relationships within any given situation (Hall, 2001). There is no subject/object binary present as both are possible depending on context (McHoul & Grace, 1993).

Discourses are productive and arise from and influence the interactions we have with each other. Discourses create speaking positions. For example, care recipients may be subject to a number of discourses that provide limits to the ways in which they can speak and act. Discourses order reality in a certain way, creating discursive structures that form our thoughts

and behaviour in a particular context but also reveal the effect of thoughts and behaviour in this context (Mills, 2004).

In gaining a sense of subjectivity, discourses provide limits to the way that intellectually disabled people can view themselves. For example, one discourse that positions the intellectually disabled as childlike and in need of protection may provide a limit to how people with intellectual disabilities — who either position themselves or are positioned by others — can view themselves in terms of functioning and ability to gain independence.

According to Weedon (1987), discourses are more than just how we think or how our social interactions produce meaning. They constitute the ‘nature’ of the body, unconscious and conscious mind and emotional life of the subject they seek to govern (1987). In this way discourses are enacted on the bodies of care recipients. Discourses also create positions of power.

Discourse and power - According to Foucault, knowledge production is an ever-changing process, discontinuous and context specific, and maintained throughout various societal structures and practices. Foucault was particularly interested in how certain discourses were prioritised over others, privileging particular versions of the truth (Barrington, 2008; Mills, 2004). According to Foucault there are no objective facts about an individual; rather, certain constructions are given a privileged or ‘truth status’ (Dean, 1993). On this basis, dominant discourses often seem natural and ‘normal’ (Cheek, 2000). As a result, power that is deployed through dominant discourses makes itself invisible to scrutiny and challenge. It is not the power of one over another that Foucault sought to examine but the ways in which power is disseminated through institutional practices in ways that both produce and control behaviour (Mills, 2004).

By identifying the discourses that exist and operate within the IDCCRA, this research reveals the power relationships that are implicit within the particular discourses. A research goal was to reveal the constructed nature of the dominant discourses and to identify less dominant alternative discourses within the IDCCRA framework. In this way discourse analysis can become a tool of social critique in which discourses are exposed that maintain unequal power relationships (Cheek, 2000; Lupton, 1992; Willig, 1999). Identifying alternative and potentially less dominant discourses will provide a means to make visible power relationships and create potential opportunities for resistance (Willig, 1999).

Disciplinary power - The Foucauldian concept of ‘disciplinary power’ has particular relevance when exploring the discourses that construct care recipients (Foucault, 1977a). Foucault defined a historical shift from execution and torture as overt forms of oppressive force and punishment demonstrated on the physical body that provided a means to demonstrate the presence of power and control to a more subtle, generalised and controlled form of disciplinary power. Foucault posited that a more gentle form of punishment through regulation and training in which the individual themselves were not just ‘object’ but also subject was far more effective (Foucault, 1977a).

An essential aspect of disciplinary power is the enactment of processes of individualisation which brings individuals into view as other and different. They are subjected to normalising judgements in which they are compared to what is considered ‘normal’. By bringing them into view, the need for control is highlighted. Identifying differences through processes of assessment allows them to be classified and organised in relation to others. According to Foucault (1977a), these strategies are essential in the enactment of disciplinary power. This research examines the enactment of disciplinary power within the confines of the IDCCRA.

Foucault also described disciplinary power in terms of a body of institutional knowledge that can be taken on as part of any institutional practice. He describes the development of specific forms of knowledge — such as criminology, psychiatry and psychology — that have created “an ‘apparatus’ composed of power relations coordinated in relationships with systems of knowledge” (McHoul & Grace, 1993, pp. 66-67). Such practices are embedded in the IDCCRA process.

According to Foucault, power is everywhere and both produces practices and provides limits to our understanding of care recipients. Foucault (1980) drew on the example provided by Bentham of the panopticon, a type of prison architectural design that he articulated as a working example of disciplinary power. The panopticon has an observation unit in the centre with cells around the outside, all viewable by prison staff in the observation unit. Foucault proposed that the design of the panopticon create the perception of constant surveillance for prisoners, even in the absence of prison staff. It was deployed as a mechanism to train people’s behaviour and created a power relationship between the observer and the observed. This was considered to be a very efficient system in terms of few resources enabling a consistent level of supervision. Like prison inmates, care recipients under the IDCCRA are required to be under twenty-four-hour supervision. The concept of surveillance and the effects of disciplinary power are explored in relation to care recipients.

According to Foucault (1977a), there are four major ways in which disciplinary power is implemented. The first of these is spatial distribution. Individuals are positioned spatially in a way that organises them and provides functional segregation, allowing for a greater level of surveillance. This allowed them to compare themselves to each other:

the disciplinary apparatuses hierarchized the ‘good’ and the ‘bad’ subjects in relation to one another ...discipline rewards simply by the play of awards, thus making it

possible to attain higher ranks and places; it punishes by reversing this process. (Foucault, 1977a, p. 181).

In this way different spaces can be a visible marker of success or failure. Care recipients may be moved from one environment to another if there is a perceived need for greater levels of control. Likewise, they can also be moved to environments in which they are accorded greater freedoms. These moves are significant for care recipients, who are subject to the successes and failures in a very real and physical way.

The second way of implementing disciplinary power relates to the control of activities. Foucault proposed that the physical body was controlled through a timetable and regulation of activities: “Life was partitioned, therefore, according to an absolutely strict timetable, under constant supervision; each movement of the day was devoted to a particular kind of activity, and brought with it its own obligations and prohibitions” (Foucault, 1977a, p. 124). Care recipients experience a high degree of regulation, with both individual service programming and the rules and regulations implicit in living in a residential service. For example, care recipients are accorded leave provisions for times when they are not under supervision and are expected to follow a strict timetable in terms of their whereabouts.

The third way of implementing disciplinary power relates to segments or stages of training in which subjects become disciplined to behave in particular ways. According to Foucault, behaviour is categorised against specific criteria, and many criteria are measured against ‘normalising judgements’ (McHoul & Grace, 1993, p. 71). Care recipients are engaged in a care and rehabilitation plan which has clear, defined goals that they are evaluated against. These are often based on what would be ‘normal’ and ‘acceptable’ standards of behaviour. They are seen as having deviated from these norms with the

demonstration of offending behaviour, and the purpose of their programme is to modify their behaviour accordingly.

The fourth way of implementing disciplinary power is the coordination of all these factors that is described as ‘overall machinery’ into which the individual body must become integrated. Foucault (1977a) described ‘tactics’ that must be engaged in so that coordination of disciplinary power can be achieved. Such techniques were developed alongside forms of knowledge such as psychiatry and psychology disciplines. These disciplines are enacted within the IDCCRA framework in the forms of assessment that take place from the point of referral to the point of release.

Limitations to Discourse Analysis

In addition, it is vital that discourse analysis does not remain at the micro level but is extended to the macro level. Research must be cognisant of the wider social and political context “by which the text is mediated and which in turn it mediates” (Cheek, 2000, p. 55). In this way discourse analysis may become a tool of social critique in which the discourses are exposed that maintain unequal power relationships. The exposition of such discourses has been a goal of the current research.

One way to assess whether discourse analysis is valid is by determining “whether an analytic scheme can make sense of new kinds of discourse and generate novel explanations” (Lupton, 1992, p. 148). By identifying new discourses, this thesis may lead to different understandings of care recipients that provide a more powerful subject positioning.

Method

Data Collection

Data was collected in two ways. The first was through semi-structured interviews with care recipients and individuals who engaged with them in a professional or support role. Semi-structured interviews allowed for some structured questions without impinging on the natural flow of the interview (Gilgun, 2005). Open-ended questions were utilised in order to generate detailed narrative data (see Appendix E for the questions). In engaging in the interviews, I started to gain a sense of discourses having developed over time. Several participants alluded to things being different either prior to or shortly following the IDCCRA being passed. I became interested in knowing if there had been historical shifts in terms of discourses that had been dominant at the time the IDCCRA was passed versus the time of the interviews.

The second form of data collection was through Hansards, a record of parliamentary debates. I decided to broaden the scope of the data to include the debates that occurred in New Zealand at the time that the Act was being passed through Parliament. Specifically, this included the Second Reading in 1999 and the Third Reading in 2003 of the Intellectual Disability Compulsory Care Bill 1999. Examining the parliamentary debates as the Bill was passed through Parliament allowed me to identify and explore any dominant discourses at the time.

The goal was to identify and analyse discourses that were evident in the words of the politicians within the social and political context of the time to identify discourses that influenced the drafting of the legislation. This allowed comparison and analysis of any discourses identified at this time with discourses identified in the words of the participants.

Data analysis occurred in the same way for both interview transcripts and the parliamentary debates as ‘texts’. Analysis of both would add richness to the data.

Recruitment

Prior to engagement in the research, comprehensive proposals (see Appendices A, B) were developed for the Regional Intellectual Disability Supported Accommodation Services in the Auckland/Northland region that defined the intentions of the research, research process, participants, risks and benefits, and the relevance for Māori.

Approval was given by the Board of Trustees of each organisation from which participants were sought before the research commenced. In addition, the Kaupapa Māori service provided a cultural advisor to give guidance on the research process and development from a Māori world view. All participants had involvement in the IDCCRA framework either as care recipients or as service providers or support people in a variety of roles. Participants were recruited from the Auckland/Northland region.

In cases where care recipients were still subject to the IDCCRA, approaches were made via their care managers. For those who were already released from the framework, approaches were made via individuals who were in a support role in the person’s life. Direct approaches were not made to care recipients to try and ensure that the choice made by the care recipient was entirely voluntary. In all but one case the care recipient, although aware of the researcher, did not have a prior working relationship with the researcher. Four weeks was given as a response time to ensure that the care recipients had adequate time to consider their decision and to discuss their participation with relevant people, such as family or support people.

Participants

Care recipients - Participants were divided into two groups. The first group was made up of seven ‘care recipients’ who had either been released from compulsory care orders within the last six months or who were likely to be released in the six months following the interviews. In terms of the inclusion criteria, a list was generated of potential participants who met the criteria. The list was provided by the Regional Intellectual Disability Care Agency that provided service coordination to the care recipients. The process was described and approved by the ethics application.

Approaches were made via email to care managers of the ten potential participants. Information sheets (Appendix C) were provided so that involvement in the research could be discussed with the individual by the care manager. This was to ensure a degree of separation from the researcher to minimise any potential for influence. It was also important that in each case the individual had an opportunity to discuss any concerns they had about participating with a support person. Where the individual had been released from the Act, approaches were made via the Regional Intellectual Disability Care Agency or through an identified support person. Of the ten individuals approached, seven agreed to take part. Although a specific age range was not sought, ages ranged from 19 to 45, with an average age of 30. Four were Māori, two were New Zealand European and one was South African. One care recipient was female and the remaining six were male.

Care recipients were living either in a regional intellectual supported accommodation service under compulsory care or independently in the community following their release from compulsory care. For those still under compulsory care, they had been so for no longer than three years.

Inclusion criteria also required that participants could converse comfortably in English. This did not present itself as an issue as, although several participants were bi- or multilingual, they were all comfortable conversing in English. All participants were verbal and able to articulate themselves comfortably.

Exclusion criteria included any individuals for whom it was considered that talking about their experiences would cause them undue stress or the potential for harm in any way. This criterion recognised that they were being asked to share very personal information that may have included some negative experiences. All participants expressed a willingness to share, and no participant expressed discomfort in sharing their experiences.

In terms of the participation of care recipients, any potential for coercion in relation to giving informed consent needed to be considered. A paper by Cameron and Murphy (2006) speaks to the complexity of engaging people with intellectual disabilities in a consent process. They cite a tension between ensuring that potential participants with intellectual disabilities understand what it is they are agreeing to and ensuring that coercion is avoided. This is because explaining what is involved could be seen as exerting influence. I sought to avoid this tension by sending Participant Information (Appendix C) and Consent Forms (Appendix D) to care managers or support people to talk through with potential participants to minimise any potential for coercion. Care managers and support people had no vested interest in care recipients taking part. However, service providers need to be well versed in the rights of intellectually disabled people when it comes to them making a choice (Cameron and Murphy, 2006). Therefore, I sought the involvement of care managers who had a specific role in relation to the rights of care recipients and as such should have been aware of ensuring their rights were protected.

Other implications that arose from the Cameron and Murphy (2006) study were the need to ensure that adequate time was given for full consideration of consent. A period of four weeks with a check-in halfway was given to ensure people had time for full consideration before agreeing to take part.

Cameron and Murphy (2006) also advised that information sheets and consent forms needed to be adapted appropriately for the audience. For the current study, a disability advisor from People First was engaged in supporting the development of the Participant Information Sheet and Consent Form that were sent out with the initial approach. People First is a self-advocacy organisation that is part of the international social justice movement that promotes the rights of people with learning (intellectual) disabilities. With the advice of the disability advisor, a plain-English information sheet was developed for care recipients to ensure they understood the nature of the research and what their involvement would look like. Cameron and Murphy (2006) asserted that consent is not a static process and that care needs to be taken to ensure that consent could be withdrawn at any point. This was made clear in both the information and consent forms and also reiterated at the start of the interviews.

Another recent study in a New Zealand context, by Taua, Neville, & Hepworth (2014), explored issues relating to research consent with people with intellectually disability and mental health issues. These included the responsibility of the researcher “to ensure that the person is protected from harm by balancing research methodologies and practices with appropriate ethical standards and the capabilities of each participant” (Taua et al., 2014, p. 514). The current research did this through a number of strategies to ensure ethical engagement with the participants.

A recent study by McDonald, Kidney and Patka (2013) found that trust was the essential ingredient for engaging in research with people with intellectual disabilities. The study used both interviews and focus groups to explore the views of adults with intellectual disabilities to gain their views on engaging in research. They found that participants wanted to engage in research that would potentially improve their quality of life. The authors further stated that “such research is more likely to be both ethical and successful if researchers pay attention to enhancing autonomy and person-centeredness, while at the same time engendering participant trust” (p. 216).

This trust building was an essential element to engaging in the research process. McDonald, Kidney and Patka (2013) stated that “despite ethical challenges, researchers can and should pursue research that has the potential to improve the lives of persons with intellectual and developmental disabilities” (p. 223). The current study was engaged in on the premise that the analysis of findings would have the potential to improve the lives of care recipients by identifying discourses and their practices which might limit opportunities.

Service providers - The second group of participants included ten individuals from a range of backgrounds including nursing, law, psychology, psychiatry, disability advocacy and support work. They ranged in age from thirty-four to sixty-five years with an average age of forty-eight years. This group included six females and two males. One parent of a care recipient was included.

Professionals and support people were approached either through the service providers or through the researcher’s own professional networks. Approaches were made by email and usually a telephone call in follow-up to the email invitation. All service providers and support people approached agreed to take part in the research.

Interviews

Care recipients - The study mentioned previously by McDonald (2012) canvassed the views of 16 adults with intellectual disabilities on participation in research. It provides some highly relevant findings. With a strong focus on respecting the participants, these included recommendations about “accommodations and supports to participate in research” (2012, p. 268). Accommodations included issues such as the timing and length of interviews, types of questions, consideration of privacy and location, and making sure the participant felt valued and knew when to stop the interview (McDonald, 2012).

I was largely guided by the responses of the care recipients in terms of how and where the interviews happened. Location was decided by the participant to ensure comfort and privacy. Interviews were managed informally, with the use of open-ended questions as a guide. Questions were worded as simply as possible and reviewed by a People First disability advisor before use. A conversational approach was taken, using the opportunity to get to know the care recipients and hear about their experiences and their views on the IDCCRA. I was affirming and positive in response to the information shared by them. I regularly asked participants if they understood the question or needed to hear it a different way.

Research by Munford, Sanders, Mirfin-Veitch and Conder (2008) argued that researchers who engage fully in the settings of individuals’ lives have a greater potential to gain a deeper understanding of that person’s experience. The authors reported that by engaging in research in a person’s home and fitting in with their daily lives, a much more engaged relationship was facilitated with participants. I utilised this strategy by meeting with care recipients in their own homes in almost all interviews. The only occasion this did not occur was at the choice of the participant in two instances.

Of note, due to my professional background as a social worker, I believe I had experience in conducting interviews with people with intellectual disability. This allowed me to take an intuitive and flexible approach to the interviews. I took care wherever possible to ensure that the normal rhythm of daily life was maintained in spite of the need to record the interviews. This meant that interviews took place as a conversation during which time phone calls were answered and cups of tea were made. My experience of this was that there was a greater level of comfort communicated by the participant and a greater level of sharing based on the engagement. This created the potential for research to contribute to meaningful change in the lives of people with intellectual disabilities (Barnes, 2003).

In considering the duration of the interviews, the potential for care recipients to become tired or lose focus was allowed for, and interviews generally lasted no longer than forty minutes. (McDonald, 2012). I was, however, guided by the participant. In one instance a participant spoke for ninety minutes. This included time for a short break and a cup of tea. The participant in this instance wanted to continue with her story. Language was kept simple and straightforward. In all cases the care recipients indicated that they were comfortable, and the interviews came to a natural close when it appeared that the participant was ready to stop.

The questions were designed to elicit responses that revealed discourses that constructed care recipients as intellectually disabled offenders. The People First representative advised on the development of interview questions to ensure that they were simply stated. The questions focused on how care recipients had found the court experience prior to compulsory care, things they liked and disliked about being under compulsory care, their understanding of rehabilitation under the framework and what their goals were for the future.

Whilst the care recipients had a range of offending histories that had led to them becoming care recipients, the questions did not in any way focus on the nature or history of their offending. This was for two reasons. The first was that, as someone who had worked under the framework, I was acutely aware of the number of times care recipients would have been asked in the course of their legal process about the nature of their offending. I viewed such questioning as likely to cause distress. Also, the nature of their offending was not the focus on the study but rather their experiences of systems and processes and the subject positions and power relationships that were offered to them and their service providers. The questions were used as a guide (see Appendix E) and do not fully reflect the conversation that took place in each interview.

Service providers - Generally, the interviews with service providers and support people lasted around ninety minutes and came to a natural close. Questions related to their perspectives on a number of issues, such as their views of care recipients, the service providers, and processes utilised under the IDCCRA in terms of release. They were also asked for commentary on the outcomes provided by the Act. Again, the questions were provided as a guide and the actual format was conversational.

Participants had the right to withdraw at any point in the process. All participants were offered a koha (donation or reimbursement) to cover any potential expenses involved in participation, as specified by the Health Research Council of New Zealand (2014).

In total, seventeen interviews were completed in June and July 2010. Having the interviews completed over this time proved a very intensive and enjoyable process. As a researcher, I underestimated the impact of the participants' words. The experiences they shared resonated for days following the interviews.

Depending on the nature of their compulsory care order, some care recipients required staff supervision during the interview. This was considered in light of any confidentiality issues that arose as part of the interview. A Confidentiality Agreement (see Appendix F) was offered to the care recipient for the support staff to sign. This would ensure that any information provided during their interview was not shared with others. In all cases the care recipient was happy for the support staff to be present without an agreement in place. The researcher also requested that support staff remained available to provide support should the care recipient become distressed through the interview process. One care recipient was engaged in ongoing therapy which was also available for debriefing following the interview.

The interviews were transcribed by a professional transcriber. The transcriber signed a confidentiality agreement. The interviews were transcribed over several months while other interviews were completed. The transcriber was offered counselling through AUT Health and Counselling should she have found the data distressing. The transcriber was comfortable with the material and did not take up this offer.

The first two interview recordings were lost following the completion of the interviews. Due to these being the first interviews, I was not completely comfortable with the recorder and managed to delete the recordings accidentally. To address this issue, immediately following the interviews I wrote down everything that I could recollect that they had shared with me during the interview. Following this I practised with the recorder to ensure that this would not recur. No direct quotes were used from the lost material, but listening to the individuals' stories aided my thinking process in terms of the comments offered by these care recipients.

Considerations for Tangata Whenua (Māori)

As this research took place in a New Zealand context, and in consideration of the four Māori who were involved in this research, it was vital that the Treaty of Waitangi was recognised in the research process (Health Research Council, 2010). The Health Research Council of New Zealand published guidelines to assist researchers intending to undertake research that may involve Māori participants or issues related to Māori health.

An extensive consultation process took place with a Māori advisor prior to embarking on the proposed research. We discussed the impact of the research for Māori and the processes by which Māori were engaged in the research. The advisor gave feedback on the Participant Information and Consent Forms, and the interview questions. In particular, the following issues were considered.

For Māori participants, the location was considered in terms of maintaining the individual's wairua (spiritual health), tinana (physical health) and hinengaro (mental health). This meant that the location was decided in consultation with them, ensured privacy and confidentiality and attended to any physical needs. Karakia timatanga (opening prayer) and karakia whakamutunga (closing prayer) were offered for the individual or support person to open and close meetings. The provision of food was offered towards the end to ensure whakanoa (clearing of spiritual energy). Participants did not want karakia, but food was provided at the end of the meeting time. Consideration of family involvement was also made but not selected by any care recipients. One care recipient chose to have his care manager present to support him, and her comments formed part of the interview transcript.

Data Analysis

Data analysis involved a multistaged and intuitive approach to the data. Immediately following the completion of the interview transcription, a first reading was completed of each transcript. During the reading, notes were made and particular comments were highlighted in relation to identifying the topics or ‘objects’ that were being spoken about by the participants. These often related to participants’ perceptions of the legislation and the rehabilitative focus that was provided by compulsory care. The care recipients’ transcripts were read to identify how care recipients understood and spoke about concepts such as compulsory care, their rights and the support provided to them. This process was used as a means to identify the discourses deployed in relation to the Act. Such discourses would be further explored to reveal power relationships and subject positions.

Some months later a close reading of the transcripts was conducted, noting further topics/discursive objects that would later become identified discourses. Questions were considered in the following areas, with each identified discourse analysed in relation to the following:

1. Identities – The speaking positions and subjectivities that were offered by each discourse to both care recipients and their support people. Resulting identities that were offered to care recipients through the constructions. What this meant in terms of identities that were available within each setting (Mills, 2004; Parker, 1992).
2. Power relations – How the different discourses positioned individuals in terms of power relationships. What discourses were dominant and appear ‘normal’ and ‘natural’. How these dominant discourses position care recipients in terms of power. In what ways did less dominant or marginal discourses position care recipients in relation to power? In what way

did care recipients position themselves in terms of power in relation to the identified discourses? Identify discourses that, once visible, had the potential to subvert the power of dominant discourses (McHoul & Grace, 1993; Parker, 1992).

3. Social relations – The relationships between the different speakers within each discourse. How the subject positioning of each speaker in the relationship impacted on other speakers within each discourse. Identify the impact that the setting had on power that each speaker had in relation to other speakers in terms of the identified discourse (Burr, 1995; Wetherell, Taylor, & Yates, 2001a).

4. Discursive practices – Practices and processes that revealed the discourses that constructed care recipients. Who carried out which practices? How processes position care recipients in terms of power. Identify practices that had the effect of disciplining. (Mills, 2004; Wetherell et al., 2001a)

5. Material conditions – The material impact of the identified discourses. For example, where did the discourse place care recipients in terms of future ability to gain employment? How did socio-economic status impact on the position that care recipients held once they were released from the Act? (Parker, 1992)

Following the reading of the interview data, I decided to complete the review of Hansards to identify discourses that were evident in the development of the IDCCRA. This exercise was the foundation of analysis of discourses that influenced the development of the Act and to consider whether dominant discourses were the same some years later, or whether, in fact, new discourses had emerged. The above questions were asked of the Hansards transcripts, and three key discourses were identified: a medical intellectual disability

discourse, a criminal discourse and a capable person discourse. These will be explored in detail in Chapters Five, Six and Seven.

Dual Role of Researcher and Professional

Engaging in this research required me to consider my roles as both a professional and as a researcher. When I started this research, I was a care coordinator under the IDCCRA. By the time of the interviews, I was in a regional manager role. It is necessary for me to make explicit the level of professional seniority I had in relation to the participants in my research. Despite this, I worked very hard to establish a more equal relationship for the purposes of the research. I also saw it as having beneficial aspects in terms of the research.

In engaging in this research, I was somehow less ‘armoured’ than I would have been in a professional capacity and open on an emotional level to the stories that the participants shared. Rather than assessor or social worker, my role was to listen. In particular, I was filled with admiration for the strength and courage that individuals had shown in the context of very difficult lives. I was also reminded by many of the important things in life that I take for granted, such as having a partner, job and secure home life. I was struck by the generosity and good humour that was shown by care recipients despite the lack of generosity that was shown to them by others. I reflected on the context of their lives in terms of being labelled as *offenders* and people with *intellectual disability*. Even today I can hear the stories they shared with me in my head.

Firstly, I had to be clear that I was engaging in these discussions under the auspices of my researcher role rather than my professional role. It was possible that information would be disclosed that revealed problematic practices within services. I was clear that I needed to just listen and not provide any response in terms of complaints they made or issues they had with

the service. It was also made clear at the beginning of interviews to both support people and care recipients that if information indicated the individual or others were at serious risk of harm, that information would be disclosed to the appropriate people. Potential participants were then given the choice not to participate if they were uncomfortable with the stated limit to confidentiality.

Secondly, I attempted to address the power imbalance, particularly in relation to care recipients. I did this by giving the participants full control over the process in terms of location, timing, duration and any other requests, such as support people that they would like to be present. I also took a very informal approach to the interview process in terms of just sitting and having a chat. I ensured that any responses I made were acknowledging, encouraging and supportive in tone.

Having worked with care recipients for the previous seven years in a professional capacity, I felt that I was able to demonstrate a level of skill in gaining the trust of participants. I did this by demonstrating integrity at every stage of the process. This meant being reliable and honest and doing exactly what I said I would do. It also meant being very respectful and valuing in my communication; not talking down to participants. Also, I used simple language to ensure I was making myself clear. I also took opportunities to acknowledge the contribution that individuals were making to the research and showed full appreciation for their participation.

In terms of participants who were support workers or service providers, any conflict of interest or potential power dynamics needed to be considered due to my professional role as a senior manager at the time. Where any potential participants reported to the researcher in an employment relationship, they were offered an alternate interviewer to reduce any potential for conflict of interest or discomfort. All identified participants reported feeling

comfortable engaging in the interview with the researcher. Despite the feedback that they felt comfortable with the researcher, it is important to acknowledge that they may have been constrained in their critique of particular aspects of the framework. However, it is evident from the transcripts that comprehensive critique was provided of the legislation and the service provision framework. Chew-Graham, May and Perry (2002) noted the importance of active engagement by the researcher:

Understanding that the interviewer may play one or more roles in an interview is important in analysing as well as collecting qualitative data. Because qualitative research is intended to give priority to the meanings and attributions that respondents bring to bear on a question, it is important to see the interviewer as someone who is actively involved in constructing those meanings, rather than as someone who is present to 'collect' them passively. (Chew-Graham, May, & Perry, 2002, p. 289).

The authors also spoke positively of professionals having dual roles when engaging in research and stated that this could lead to a greater level of comfort and participation on the part of the participants (Chew-Graham et al., 2002).

Chew-Graham and colleagues (2002) also cautioned that a level of bias can occur. I attempted to address bias through both naming the assumptions in this chapter that I have held as a researcher engaging in research with this group and then checking my biases against findings. In terms of the participants who were service providers, many of them were individuals that I knew well in a professional capacity. Chew-Graham and colleagues asserted that with a level of familiarity between researcher and participant, interviews can lead to a richness of responses compared to interviews with strangers (p. 288). They also stated that such a relationship can potentially lead to conceptual blindness, "allowing the interviewers' own feelings and opinions about the field to govern the dialogue and

interpretation” (p. 288). It is very possible in relation to the current research that my feelings and opinions had an influence on the interviews. As stated above, I have attempted to address this by naming my assumptions below and checking those assumptions when considering the findings.

Despite the fact that I worked hard to maintain an equal relationship in terms of interviewer and interviewee by giving as much choice and control to participants as I was able, I still retained a position of power in the relationship. By making explicit my status, my experience, my professional training and my assumptions, it is hoped that the rigour of the qualitative research is maintained (Bradbury-Jones, 2007).

As a social worker who has worked with the IDCCRA for the last twelve years, I held assumptions that would have a potential influence on any findings. The first assumption I held was that people with intellectual disabilities and who are going through the criminal justice system would have experienced discrimination and marginalisation in their lives. Holding this belief led me to engage in social constructionist research that would allow an exploration of the way in which care recipients may be constructed by dominant discourses, with the goal of revealing alternative discourses that may offer a more powerful subject position. Other assumptions related to them having had negative experiences with both the legal process and whilst living in a residential service. I assumed that they were capable of achieving far more than they were currently demonstrating. I also assumed it was likely that they had experienced some form of abuse in their lives.

Ethical Considerations

Ethical approval was sought through the New Zealand Northern Regional Health and Disability Ethics Committee and approved prior to the commencement of the research project (NTX/10/04/029). The ethics committee guidelines informed all aspects of the research.

In terms of gaining consent, it was essential to ensure that participants fully understood information regarding their involvement in the research (Eckhardt & Anastas, 2007). People with intellectual disabilities are sometimes more likely to be acquiescent when dealing with people whom they view as being in a position of power to them (Stalker, 1998). As already identified, my professional roles placed me in a potential position of power. This made it even more important that informed consent was gained. To limit any potential for coercion, consent forms were provided to key support people for discussion with potential participants before signing. Plain English information sheets were also provided for discussion. Establishing a robust consent process was to ensure an ethical approach to the study (Stalker, 1998).

Issues of risk and vulnerability were considered throughout the process (Health Research Council, 2014). All participants were given a pseudonym to ensure confidentiality. Psychological risks included potential distress for care recipients due to talking about their experiences of going through a legal process and being under a compulsory care order. In preparation for the interview process, I spoke with the care manager or support person to ensure that there was a trusted support person available for the participant to talk to following the interview. This was in some instances a key worker, care manager or other support staff. Follow-up counselling was also available through AUT Health and Counselling for participants who found the interview upsetting but was not taken up by any participants.

One of the factors that needed to be acknowledged and considered in talking to care recipients is the high incidence of abuse experiences for intellectually disabled people, as indicated in Chapter Two (Marita McCabe, 1994; Sequeira & Hollins, 2003). One care recipient, 'Kelly', disclosed abuse that she had experienced whilst in service under the IDCCRA. The care recipient was supported during the interview by a long-time close friend. Following the disclosure, I acknowledged the experience and offered to cease the interview.

This particular participant was the only participant that I had known in a professional capacity, having been in a previous support role to her. I believe that this, along with the presence of her friend, created a level of comfort and safety in sharing her story, and the interview continued. I was aware at the time of the interview that Kelly had endured a police investigation and court case in relation to the sexual assault she had experienced. I was also aware of what had occurred, due to my professional involvement in her care, on the part of the provider, the police and the Ministry of Health. Had I not been aware of these facts, as a researcher I would have followed up with the provider to ensure that appropriate action had been taken. I also confirmed that Kelly was engaged in ongoing sexual abuse counselling and would have the opportunity to talk further following the interview. I again followed up with her some months later to update her on the research and to ensure she was still comfortable with her involvement. I also discussed the disclosure with my supervisors in light of my role as both researcher and professional in relation to Kelly. One of my supervisors contacted AUTEK (AUT Ethics Committee), which confirmed that it perceived no ethical issues in the process undertaken.

Another ethical issue arose in relation to engagement of people with intellectual disabilities in the research process. Much has been written in recent years about the need for emancipatory research in which disabled people are involved as consultants and partners, and

not just subjects (Barnes, 2003; Kitchin, 2010). The view is that non-disabled academics engage in research for their own gain in a process that can be viewed as exploitative.

Discourse analysis requires the particular perspective of the researcher to be made explicit, as this also has influence (Dean, 1993). In engaging in the analysis, I was aware that as a social worker and feminist who had a particular interest in social justice, I would intuitively seek out data that related to discriminatory practices for this group. As discrimination for this group is well documented (Sullivan & Munford, 1998; Taylor, 2005; Tennant, 1996; Ypinazar & Pagliano, 2004), it seemed likely that this theme would emerge from the data, regardless of any preconceived notions on my part as the researcher.

Despite my perspective, I could not interpret issues for disabled people on the basis of having had that experience myself. In interpreting my findings, I was acutely aware that in creating an opportunity for people with intellectual disabilities to talk about their experiences, this might allow new or subordinate discourses that offered them different, more powerful subject positions to be articulated.

According to Barnes (2003), qualitative research lends itself far more to emancipatory research for disabled people than quantitative, based on the ability to capture the full spectrum of their lives and experiences of oppression. Emancipatory disability research was a term developed by Oliver (1992) and defined a new and different way of conducting disability research. It was defined as Barnes as, “the systematic demystification of the structures and processes which create disability and the establishment of a workable dialogue between the research community and disabled people in order to facilitate the latter’s empowerment.(Barnes 1992, p.122). I have explicitly named an assumption that the study will reveal discriminatory practices. I have also named a very specific intention to reveal constructions that provide more powerful subject positions for care recipients. Therefore the

current research reflects the values of emancipatory research. I would not however lay claim to this being emancipatory research in that first, emancipation is not an outcome consistent with a post-structural approach and second there was no co-research process including a disabled person as researcher.

Recent research by McDonald (2012) emphasised the importance of respect for people with intellectual disabilities when engaging in research. These values were supported in a New Zealand context by Bray (1998), a significant researcher in the intellectual disability field in New Zealand, who insisted that any research undertaken with people with intellectual disability is done to improve the lives of people with disability and influence positive change (Bray, 1998). The consultation with People First during this research process has been an attempt to address this. The findings of the research will also be presented to People First.

Rigour

One of the criticisms of qualitative research is that it lacks rigour in terms of reliability and generalisability (Bradbury-Jones, 2007). Various techniques are available for qualitative researchers to both enhance reliability and protect against bias (Grbich, 2013; Mays & Pope, 2000). By allowing the reader to audit the events, influences and actions of the researcher, it may be possible to establish a level of trustworthiness in relation to the research (Koch & Harrington, 1998). In each case the participants were offered the opportunity to review the transcripts of their interviews and give any feedback. In the case of care recipients, I offered to meet with them and go through their transcripts in person. Only one participant took this opportunity and provided minor feedback.

Establishing rigour requires engaging in a reflexive research process. According to Koch and Harrington (1998), reflexive research is characterised by “ongoing self-critique and

self-appraisal and that the research product can be given shape by the politics of location and positioning” (p. 882). According to Munford and colleagues (2008), the achievement of rigour related to ensuring the findings captured the meanings of experiences in the lives of participants. The current study has done this, ensuring that findings have a direct link to the experiences of both care recipients and service providers.

Reflexivity

Reflexivity requires researchers to understand how their personal feelings and experiences influence a study and then attempt to integrate this understanding into the study (Bradbury-Jones, 2007; McNair, Taft, & Hegarty, 2008) by making these assumptions explicit. This is particularly important when conducting research involving highly vulnerable groups, which may be even more susceptible to the influence of the researcher’s implicit assumptions and beliefs (Scior, 2003, p. 793). Researchers’ beliefs influence the interview questions and method of analysis. This is a reciprocal relationship with the research environment, with subjects and processes also having an influence on the researcher. The process of reflexivity acknowledges these influences and integrates them into the report to ensure that a more comprehensive interpretation of the data is provided (Lamb & Huttlinger, 1989).

To remain reflective throughout the research process, I engaged in a journal writing process. This enabled me to make my prejudices explicit and reflect on my own assumptions and perspective throughout each stage of the research process. Whilst I did not refer to the journal routinely, I reviewed it in preparation for writing my findings chapters. Reviewing the journal allowed me to review any changes to my assumptions and perspective. Being reflective meant that I could make explicit my status in terms of my professional roles during

this research process. In reviewing the journal, I was interested to find that many of my initial thoughts and impressions were later reflected in the comments by the participants.

Summary

In this chapter I explored the philosophical underpinnings to the research that has provided the framework for engagement. Also described was the methodological process. I focused on strategies that ensured that engagement with a group of vulnerable individuals was ethical, effective and sound. In engaging in the data analysis, three discourses have been identified that I explore in more detail in the following chapters.

CHAPTER 5 – THE INTELLECTUAL DISABILITY DISCOURSE

Introduction

In this chapter I show the way that ‘intellectual disability’ and care recipients as ‘intellectually disabled’ individuals in this study have been discursively constituted under the IDCCRA. I will also demonstrate how an intellectual disability discourse discursively constitutes service providers. As described in Chapter Three, the development of the legislation happened within the context of deinstitutionalisation and significant changes in the way that people with intellectual disability were viewed and treated (Shalock, 2011).

Discourses are located within a specific historical and social context. Discourses may change over time, with human subjects having multiple and changing subjectivities (Weedon, 1987). I explored two key periods of time in relation to the Act within a historical context: the first was the parliamentary debates that happened at the time of the second and third readings of the Act in 1999 and 2003; the second was the words of the participants shared in 2010.

I argue that despite the social and cultural context changing over a period of seven years, the dominance of what I have identified as an intellectual disability discourse during the parliamentary debates endured, as evidenced in the words of the participants in 2010. Even in the broader context of the New Zealand Disability Strategy (Ministry of Health, 2001a) and the United Nations Convention on the Rights of Persons with Disabilities, the dominance of the intellectual disability discourse is still evident in legitimising the way that intellectually disabled people are viewed and treated.

The Medical Model

Based on a medical discourse, the intellectual disability discourse constructed care recipients as ‘permanently impaired’, ‘vulnerable’ and ‘risky’. As such they were accorded limited rights and autonomy by service providers. Constructions of ‘intellectual disability’ presented as ‘truth’ statements by an intellectual disability discourse draw on assumptions about people with intellectual disability and appear ‘normal’ and ‘natural’. Service providers were constructed as being in a parental role, with a focus on meeting disability support needs and having control and authority over care recipients.

Until recently, supports have been driven by what I have identified as a medical discourse that constructed individuals with an intellectual disability in terms of biology and permanent neurological impairment. In terms of permanent impairment, it was considered that their brains would never develop in the same way that non-neurologically impaired individuals would. They were considered to have development that would only reach that of child years, for example, often being described as having the mind of a five-year-old, as indicated in the previous chapter.

Foucault identified the development of new forms of knowledge in the 19th century related to industrialisation and the need to control groups of individuals within society (Foucault, 1977a). One particular focus was that of criminal tendencies and led to the creation of new forms of knowledge such as psychiatry and psychology. Defined by Foucault as the medical gaze (1977a), these new forms of knowledge supported the development of processes of assessment that served to highly individualise the subject. Individualising care recipients served to highlight points of difference, both bringing the person into view and marginalising them through normalising judgements.

The medical discourse constructed people with intellectual disability as inherently impaired. With a medical basis to their impairment, they could be provided with treatment but would never be considered cured, based on their perceived permanent limitations (Ministry of Health, 2003b). For theorists such as Foucault, medical knowledge has been integral to the construction of “notions of ‘health’ and ‘normality’ within its moral framework” (Petersen, 1994). The dominance of the medical discourse in the 19th and 20th centuries in New Zealand led to the long-term institutionalisation of individuals with an intellectual disability who were considered a burden and in need of institutional care (Milner, 2008; Sullivan, 2005).

On the basis of being impaired, potential care recipients were considered to have a range of functional and/or ‘special’ support needs. ‘Special needs’ is a term that has been used extensively in relation to people with disability and is thought to create a process of ‘othering’ for people with intellectual disability (Ypinazar & Pagliano, 2004). According to Foucault, the process of ‘othering’ has to do with power acting through knowledge in order to achieve a goal of control (Foucault, 1980). Understanding care recipients in a particular way allows them to be marked as different. In essence, othering has the effect of marginalising people with intellectual disability.

Subject Positions

Permanently Impaired Person

During the developmental phase of the IDCCRA, a number of comments made during the parliamentary debates reflected the notion of permanent impairment for potential care recipients. A *permanently impaired* subject positioning for care recipients positions

them as *always* having limited capacity. This impairment is considered ‘life-long’, as demonstrated in the following quote by Heather Roy MP (2003):

Intellectual disability, of course, is a lifelong condition. It is a description of somebody's intellectual capacity. When people are disabled, the measurement of their disabilities cannot be improved upon. The implication is that people's behaviour can be improved, and that indeed is sometimes the case, despite the fact that these people are often functioning at a very low level throughout their lives. But the base from which they operate will never be able to be changed with treatment. (Roy, 2003, p. 9571).

Roy made the statement ‘of course’ as if it was a generally accepted view. Intellectual disability was portrayed as measurable and predetermined in terms of shutting down any potential for improvement. She also separated out ‘behaviour’ as being able to improve, with an underlying pathology or ‘base’ that would remain at a ‘low level’ for life.

The concept of intellectually disabled offenders being ‘behaviourally challenged’ was reflective of the thinking at the time of the development of the IDCCRA where there was a focus on ‘high and complex’ needs and ‘challenging’ rather than ‘criminal behaviour’. Complex or challenging behaviour was defined as referring to “the need for multiple involvements from health and disability, education, welfare, and/or justice systems alongside family and advocates” (Health Funding Authority, 2000, p. 6).

As discussed in Chapter Three, some of the early reports provided to government described intellectually disabled offenders as having ‘challenging behaviour’ (Health Funding Authority, 2000; Ministry of Health, 1996). Potential care recipients were

constructed as presenting a risk to others based on their disability. This is reflected in the following statement made during the parliamentary debates by Pita Paraone:

We must accept that some people in our society are not able to participate in a normal way, because of the dangers they pose to themselves and others. Secure care or constant supervisory care is necessary for those people, and I do not mean locking them up in prison with criminal offenders. This bill is an attempt to ensure the correct balance between proper care for the people who are affected and the rights and the safety of the community. (2003, p. 9561).

Whilst the need for social control was cited in terms of the rights and safety of the community, it was also stated that an alternative to prison was necessary. The perceived need for social control provided the justification for the historical institutionalisation of people with intellectual disability, as described in Chapter Three.

The permanently impaired subject position was very difficult for care recipients to move beyond, as reflected both during the parliamentary debates in 1999 and 2003, and in the words of the participants in 2010. For example, in talking about the way in which the consultation process rendered potential care recipients ‘voiceless’ based on the notion of permanent impairment with limited capacity and understanding, Judy Keall MP said the following:

it will be very important for the committee to listen carefully to the submissions made by the provider groups, the carers, and the parents of this small group of people, who number only about 200 and who need special care. (1999, p. 19700).

Due to perceptions of their limited capacity, it is interesting to note that Keall did not consider potential care recipients for consultation. Care recipients were constructed as

incapable of engaging in a conversation about their own welfare. It was thought necessary for other people to represent their views. This belief was further supported by a comment made by Goudie, another MP:

I know that a number of families out there will be so thankful knowing that their children at whatever age will be in a safe and secure environment when they can no longer look after them. That is what this bill does. It provides them with some comfort and measure of hope that that will happen for their children. (2003, p. 9567).

Potential care recipients were constructed as both *at risk* and *risky* based on perceived permanent impairment and inability to understand things in the same way a non-disabled adult would. The individual was described as a child 'at whatever age'. They were constructed as unable to move on from 'child' status into adulthood. They were also constructed as incapable of looking after themselves and in need of support from others.

With permanent impairment, potential care recipients were constructed as unable to be held responsible for their actions. Lynda Scott stated the following in the parliamentary debates:

The aim of the bill was to determine that intellectually disabled persons who had committed a criminal offence and who could not be held responsible for their actions could be placed in permanent care and have a secure environment. (2003, p. 9559).

Underlying impairment implied a lack of understanding in regards to actions taken and therefore a lack of culpability. The subject position of being permanently impaired was also deployed some years later by participants. Walter, a service provider, spoke of care recipients who were trying to find a job following release from compulsory care:

They [potential employers] still view the person as actually having a disability and they pose a risk in terms of health and safety and OSH [Occupational Health and Safety]. Because the person has a disability, can they read, can they write, can they understand warning notices, can they be taught how to do [tasks], a majority of this stuff is obviously manual labour, can they understand that their behaviours or what they do at work has a risk to other people in terms of not following commands or instructions correctly? So people are often deemed a risk and unemployable even before they've tried or been given a chance to do so. So a lot of these guys are going to end up being on the benefit, beyond the point of leaving.

The potential employers based the employment decision on a construction of the individual as having limited capacity and ability. Questions were raised about whether they could do the job as well as someone without an intellectual disability. The perceived limitations were then escalated as risks to the employer or workplace in terms of safety. The individual was constructed as risky, vulnerable and problematic and therefore unlikely to be employed. They are considered more vulnerable than other employees based on their disability.

The Vulnerable Person

One participant, Barney, an advocate, talked about what happened once a care recipient was released from compulsory care:

The first minute they're out, they're really, really vulnerable to something happening. In fact that's the most vulnerable time. Nobody's looking after them at all. Nobody's even taking care, there's no oversight.

An intellectual disability discourse constructs care recipients as vulnerable based on their impairments and a perceived inability to understand danger in the same way as others. Barney positions the care recipient as needing someone to ‘take care’ and ‘watch over’ them. He stated that once they are released from compulsory care this may no longer happen. The supervision that was provided whilst care recipients were under compulsory care was constructed as necessary due to their vulnerability.

Once this protective supervision was no longer in place, their vulnerability was perceived to have increased. There was an implication that society posed a threat to people with intellectual disability. In this instance Barney was talking about a care recipient who chose to live independently rather than move to another residential service. It was constructed that as an intellectually disabled person that he needed to be ‘in care’. Again, the need for ‘surveillance’ and systems of support were enacted (Sullivan & Munford, 1998). The need for surveillance was integral to the enactment of disciplinary power. Systems of surveillance seek to create docility in the care recipient, who, even in the absence of constant supervision, modifies their conduct (Foucault, 1980).

As a result of a vulnerable subject position, care recipients were constructed as at risk to themselves or others based on this need for support and needing to be controlled in a secure environment. Harriet, a service provider, stated the following:

There has been the odd instance where people have tried to take on that paternalistic view that the person needs a residential service. We had one person who was living on the streets and he was a nuisance and nobody knew what to do with him. In the very early stages he was made a care recipient and I think now that we’re further down the track and more experienced we’d be saying this is a social need and you’re

using the criminal court process to meet somebody's social needs and housing needs.

The effect was a lack of agency for the intellectually disabled person, who was perceived as incapable of having any level of independence. The dominance of constructions such as permanent impairment created the perception that placement in a residential service was necessary.

Special Needs Person

The IDCCRA also specified a number of needs in relation to the care of care recipients that represented broader social needs. For example, Section 26 (1) specifies that the care and rehabilitation plan must identify “(f) any special concerns and aversions of the care recipient”, “(g) any special dietary needs of the care recipient” and “(h) any other special needs of the care recipient” (Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003).

In terms of identifying or meeting the needs of offenders, it was thought to be unusual to have reference to dietary needs in legislation (Duncan, 2013). Deploying an intellectual disability discourse at the time of the drafting of the Act, it was considered necessary to meet the needs of this group as offenders but also as people with intellectual disability who were considered to have a number of functional and ‘special needs’.

Dangerous Person

As already identified, any perceived lack of functioning constructed individuals as not only ‘vulnerable’ but also ‘risky’ and ‘dangerous’. Franks, an MP, stated the following in the parliamentary debates:

This is the bill that explains how people will deal with those who are so subnormal that they will be a threat to others and have committed crime. 'Subnormality' was cited as the direct cause of the perceived dangerousness. This comment served to further pathologise care recipients who were unable to overcome permanent impairment and therefore have little hope of change. (2003, p. 9562).

Care Providers as Parental Subjects

An intellectual disability discourse creates a parental subject position/subjectivity for service providers. One participant, Whitney, a service provider, spoke of the role of direct support workers:

You know, one of our biggest struggles around the Community Support Workers is getting them to understand that actually this is not an extension of your family. You cannot respond to these guys like you do your own sons and daughters. But that's the only thing the [community support workers] have to draw upon, you know, so it becomes really, really difficult to get them to stop and step back and think differently.

Whitney suggested that support workers assumed a parental role in which they spoke for and 'managed' the behaviour of the care recipient as if they would their own child. As 'parental' subjects, support workers were also subject to a range of familial subject positions. This was further stated by Mary, a service provider:

I think people were just, often don't have a model other than their own, their own experiences in terms of friendships and relationships and families. So when they come to work, when they get into trouble that's their fall back option.

Drawing on the notion of people with intellectual disability as childlike, vulnerable and needing care, support workers were constructed as parental. As ‘parental’ subjects, support workers occupied a position of power in relation to care recipients. Support workers were responsible for both supporting and supervising care recipients in the twenty-four-hour residential service to attend to self-care and engage in their daily activities.

Both Mary and Whitney signalled the issue of training for service providers, who largely came from experiential rather than professional backgrounds. Signalled by both was the notion that a lack of training provided a limit to the range of responses that support workers utilised with care recipients.

Discursive Processes

Constructing an Intellectual Disability

According to Foucault, discourses produce discursive practices that are specific to time and place in history (Foucault, 1972). Disciplines such as psychology and sociology were developed along with medicine in response to industrialisation and the perceived need to control the growing populations in cities during the 19th century (Foucault, 1977a). Foucault was particularly interested in the role of these disciplines in the social management of individuals.

The IDCCRA has a set of specific discursive practices that serve to legitimise both entry into the Act and the systems of support that are implemented once under the Act. These include the process of diagnosis and determining eligibility according to the criteria for intellectual disability. The assessment process was conducted by psychologists who are designated as specialist assessors under the IDCCRA.

The psychological testing of intellectual capacity was part of an apparatus or system that has caused the emergence of the discursively constructed object ‘intellectual disability’ and the resultant subjectivities that are produced for both the person with intellectual disability and practitioners. Psychological testing was relatively new, and the diagnostic criteria of intellectual disability have faced significant change over the years. In 1938, for example, the term ‘mentally defective’ was used with three groups described by the Royal Medico-Psychological Association: idiots, imbeciles and the feeble-minded (Burrell & Trip, 2011). These descriptors were discursive constructions deployed through processes of diagnosis and assessment that were carried out with individuals.

The more modern assessment of intellectual disability used in relation to this Act was a discursive construct that was based on determination of a ‘normal’ distribution of ‘intelligence’ within a population (Weschler, 2008). Our understanding of intellectual disability was based on the ways in which mental ‘abilities’ are constituted and become a measure of normality. Without understanding ability, we are not able to understand *disability*. Diagnoses do not just describe; they in fact construct (Goodley, 2011).

Participants reported a number of assessment processes that occurred during the court process prior to referral for consideration of placement under the Act. Enactment of these processes required court staff to identify offenders as ‘different’ and in need of further assessment to establish an offender’s levels and nature of impairment. As stated by one service provider, Harriet:

There are flags raised in terms of fitness.

‘Flags’ referred to the person being perceived as different from other offenders. The term fitness relates to the individual’s ability to instruct their lawyer and understand the legal

process. Implied here was a complex process that required certain cognitive abilities that a person assessed as being ‘unfit’ did not have.

By identifying the need for a different criminal justice process, potential care recipients became differentiated from ‘normal’ criminal offenders. Whilst an intellectual disability was not necessarily diagnosed at this point, in a Foucauldian sense this process subjected them to a process of individualisation in which the assessment process highlighted their differences from others.

As explained in Chapter Four, the process of individualisation brings individuals into view as other and different. Identifying differences through processes of assessment allowed potential care recipients to be classified and organised in relation to others. They were subjected to normalising judgements in which they were compared to what was considered ‘normal’. By bringing them into view, the need for control was highlighted. According to Foucault, these strategies are essential in the enactment of disciplinary power (Foucault, 1977a). Being marked as different also ensured that care recipients were not disadvantaged by the court process by being subject to the processes (and determined to be criminally responsible) in the same way as ‘normal’, that is non-disabled, offenders.

Fitness processes are detailed in Section 38 of the Criminal Procedures (Mentally Impaired Persons) Act that provides the procedures for entry into IDCCRA (Criminal Procedures (Mentally Impaired Persons) Act, 2003). During this process an individual may be identified as potentially having an intellectual disability. Fitness issues could be raised in relation to a variety of individuals and not just those who were thought to have an intellectual disability. It could not be assumed that someone found ‘unfit’ had an intellectual disability or that someone with an intellectual disability was automatically ‘unfit’. As stated by Walter, a service provider:

[The section 38 assessment will] often provide a very small glimmer in terms of whether a person may have a cognitive deficit which could then entail: does the person have an intellectual disability?

Once identified, individuals were referred for assessment by a 'specialist assessor' to determine eligibility for compulsory care and rehabilitation under the IDCCRA. As stated in Chapter Three, in Section 7 of the Act an intellectual disability required three criteria to be met. Criteria included an assessed level of permanent subaverage intelligence, deficits in adaptive functioning and evident prior to the age of 18 years (Intellectual Disability (Compulsory Care and Rehabilitation) Act, 2003). The criteria in the IDCCRA are based on the standard diagnostic criteria and measures in use within New Zealand and internationally (Duncan, 2013).

As described by one participant, a service provider, Darcy:

So eligibility is the first part, you can't go under the Act unless you're eligible, and in order to be eligible there's a clear set of criteria that you have to meet that are specified in the IDCCRA Act. And it's one of the principal roles of the specialist assessor is to ensure that somebody meets those criteria.

As noted above, an intellectual disability diagnosis required a permanent impairment to be identified. It was considered that, based on the identified permanent impairment, an intellectually disabled offender could not be subject to the same legal process as a 'normal' offender. This was based on an understanding that they may not have the same understanding of the crime they have been charged with or the consequences of their actions.

Discursive Limits

The subject positions provided above were given legitimacy and authority when key decisions were made regarding service provision in relation to the IDCCRA. This was because understanding of these individuals was developed within discursive limits. Discourses are defined by a “delimitation of a field of objects, the definition of a legitimate perspective for the agent of knowledge, and the fixing of norms for the elaboration of concepts or theories” (Foucault, 1977b, p. 199). Discourses do not act in isolation from each other. I will show that the intellectual disability discourse interacts with what I have called the criminal discourse and the capable person discourse, which are described in Chapters Six and Seven.

In a practical sense, the dominance of the intellectual disability discourse evident during the development of the Act led to an action by government to contract disability support providers to provide both supports and placements under this framework (Prebble et al., 2013). Constructions of intellectual disability as permanently impaired, ‘vulnerable’ and ‘risky’ also led to the development of a framework of supports that would provide full-time residential compulsory care and meet perceived disability support needs.

Disability Support Needs

The normalising practices produced by the intellectual disability discourse and performed in the care settings appeared to be strongly focused on the meeting of perceived functional support needs by service providers. As stated by Walter, a service provider:

The residential would obviously focus specifically around their daily living skills and whether they’re in a safe environment, whether they’re able to look after themselves, personal care, maintaining health, general living abilities.

This excerpt suggests an assumption, based on intellectual disability as a permanent and unfixable impairment, that care recipients would need support to engage in the everyday activities that ‘normal’ people take for granted to ensure safety, health and well-being. Another participant, Fay, a lawyer and service provider, problematised the focus on functional needs:

There are things like hygiene and cleaning your teeth and I see these in the plans constantly. They get very repetitive and may be for a good reason but is that rehab? Is that care and rehab or, is that something that’s just there to fill up the time and fill in the space. I think the rehab side of the legislation is not being addressed thoroughly and realistically.

Fay offered an alternative construction of intellectual disability that positioned care recipients as engaging in something more than having their functional support needs met. She identified a process of rehabilitation that she perceived as being required by the legislation. Whilst this was not defined by Fay, it was articulated as something ‘more’ than just meeting daily living needs.

This was also articulated by Harry, a care recipient:

Rehabilitation is like, you know, making sure that you, you having a shower and you know you’re brushing your teeth and it’s not. You don’t need that.

Harry identified that it was assumed by service providers that he needed support to brush his teeth and have a shower. Drawing on an intellectual disability discourse meant that a meaning of rehabilitation that considered needs other than disability support needs was shut down. It also meant that strengths he had in those areas were not identified. The focus on disability support needs limited Harry’s opportunity for improvement as his needs, as

perceived by him, were not met. This was further articulated by Barney, a service provider, who said:

I mean they do the basic, like cooking skills, that's very handy, but [you need to] teach people how to live with other people in the community, which is obviously a prime requisite if you're disabled, and how to address the concerns that brought you in here the first time.

Barney positioned the care recipient as *other* and requiring specific rules in terms of living with others in the community based on having a disability. He also positions them as needing something 'more' in terms of addressing the concerns that brought them under the Act. Concerns may relate to the ability to support themselves independently without engaging in criminal behaviour. Criminal behaviour may have included behaviours such as sexual offending, committing burglaries or assaulting others. Skills related to living with others meant behaving a manner that would not put others at risk; for example, threatening others when there was a disagreement. A focus on community integration was prioritised in terms of the individual learning how to behave in a way that positioned them as potential 'good' citizens.

The rules, both with the service and within the community, demonstrated the evidence of disciplinary power. Whitney, a service provider, spoke in detail around the rules of living in a residential service:

I'm often having conversations with all the clients around it is difficult to live in services because there are lots and lots of rules, you know, and society has rules but generally they're not as frequent if you like or as obvious on a day to day basis as the rules you live by when you're living in a service. I mean if you move into a flat,

there are rules but you know they're different and they're made by you and you own them you're not, and you don't feel that you know, upon you sort of thing. I think it would be very, very difficult to live in a service.

Care recipients were required to follow a regular timetable of activities as part of their care and rehabilitation plan. Providers were also subjected to a level of rules and regulations.

Residential services are required to have a number of policies and practices that meet the standards of the Health and Disability Services Standards 2008. The standards were created for the purpose of providing the “foundation for describing good practice and fostering continuous improvements in the quality of health and disability services” (Standards New Zealand, 2008, p. 7). Also referenced are the rights of service users, highlighting the need for protections for a group that is considered to be highly vulnerable.

Residential services are required to demonstrate that they meet these standards through Ministry of Health mandated auditing processes. They are also required to institute some level of standardisation to maintain efficiencies when dealing with multiple service users. Disciplinary power was demonstrated through the rules and requirements of the residential service. These processes were legitimised by the requirements in law and in the name of efficiency.

Individuals were differentiated from each other by means of a rule that was the required standard of behaviour. What this meant was that to be successful in the residential environment, it was necessary to follow the rules of that environment. The aim was to train the clients in order to modify their conduct so that it matches that of a ‘good citizen’. It was required that the same rules be followed by all.

Financial Implications

Some care recipients were engaged in full-time employment before becoming care recipients. Once placed under the Act, options for employment became very limited by disability services, providing more of a focus on day activities and recreation rather than employment. As stated by Holly, a service provider:

I think that it's a little bit disappointing that sometimes we have people who become care recipients and have been fully employed and have been working prior to becoming a care recipient. [They] become a care recipient and are placed and you know they attend day services which is perhaps not challenging enough or meeting their needs or it's very difficult to find employment especially if a high level of supervision is required. I think that the focus should be more on vocation and finding employment rather than day activity and recreation.

The dominance of the intellectual disability discourse has particular effects on the care recipient. The care recipient was no longer able to engage in full-time employment. This was in part due to being constructed as 'risky' both in relation to their intellectual disability and their criminal behaviour. The latter will be discussed in Chapter Six in terms of an offender subjectivity. It was also due to them having been constructed as permanently impaired and not having the skills. Holly reflected that placement under the Act had an impact on the care recipient's quality of life. There was the economic impact for the person in terms of no longer earning an income, but also a level of boredom and dissatisfaction in terms of the activities the care recipient was offered whilst under the Act. She also noted that the care recipient's abilities were above those assumed by the vocational provider.

Kelly, a care recipient, had lived with a relative degree of independence prior to compulsory care. She was able to manage her own money, follow a budget and keep her own records. She was very unhappy to find that her finances would be managed by service providers upon entry into a residential service and said:

I'm not going to hand you over my books thank you very much. I'm very, very fussy when it comes to my bank books. When it comes to somebody else looking into it I don't trust them at all.

For Kelly, placement under the IDCCRA meant that she was constructed as incapable of managing her finances. An intellectual disability discourse was deployed by residential service procedures that required that financial records for individual clients were managed by service providers. Based on the construction of people with intellectual disability as permanently impaired, there was an assumption that they were not capable of managing this for themselves. The residential environment required compliance from Kelly to abide by these rules in order to have the potential for moving on from service. Also indicated was a power relationship in which it was considered appropriate for the provider to have such control over Kelly's money.

Power Relationships

A vulnerable (and lacking) subjectivity was deployed in terms of the assumption that if these procedures were not in place the clients were vulnerable to financial abuse. For Kelly, such policies positioned her as incapable of managing her finances herself. They also positioned her as powerless as she didn't feel she had any choice. She felt similarly about other aspects of her care, such as:

The rules, being controlled. Being told, get up now, eat now.

Abuse of Power

The power relationship between care recipients and service providers was problematised by Hannah speaking about the care provided to her daughter:

When staff talk to her and tell her that she's stupid or that she's behaving like a five year old and she's this that and the other thing, and taking over, so she can't use her Lazy Boy [arm chair] and she can't do her own puzzles, you know, that's hers. It's also been witnessed by her computer teacher when this lady spoke to her very rudely and slammed the door on her face. Now, the difficulty is that [the service] will not acknowledge that that has happened.

Hannah deploys a vulnerable subject position for her daughter but describes the unequal power relationship enacted by the residential environment as being abusive. There was an abuse of power demonstrated by staff, who failed to treat her daughter in a respectful manner.

The intellectual disability discourse constructed Hannah's daughter as somehow less important based on her permanent impairment. She was not considered by service providers as being entitled to the level of respect that others without an intellectual disability would be. She was disempowered, with a range of choices being taken from her as if she was not capable of making these choices for herself. This behaviour on the part of service providers was constructed as normal and acceptable in the context of the power relationship. The service providers took on an abusive role both in terms of their behaviour and in terms of the response to Hannah. In this way the intellectual disability discourse can be viewed as shutting down the basic human rights of care recipients.

Hannah had positioned herself as an advocate for her daughter for many years. Her role as mother and protector had been extended due to her daughter having an intellectual disability. With her daughter coming under the Act, she felt that her advocacy role was marginalised due to the powers of compulsory care:

With her being under an order those that were responsible for her care and rehabilitation, their powers overrode mine. So that really worried me because at that stage and even, even now but to a lesser degree, I have never felt that they've acted in her best interests. You know right from the very beginning I felt that, I have to protect her from the people that are supposedly caring for her. So you know while she was under that order that made things very anxious for us you know.

Hannah identifies that where an unequal power relationship exists, there was potential for abuse of her daughter by service providers. The care of Hannah's daughter had been taken on by the state, and in the deployment of an intellectual disability discourse it had established a potentially abusive power relationship. Whitney, a service provider, also identified the potential for abuse to occur, saying:

Yeah unfortunately, human services attract people who like to have power and control over others. I mean, that's a fact. And every now and again you're slapped with the ugly evidence of it.

As a service provider, Whitney had experienced managing staff who had engaged in abusive practices with care recipients. She saw this as demonstrating both the vulnerability of this client group and lack of training for service providers. She also saw it as reflective of the fact that in some cases predatory individuals were attracted to working in services with vulnerable individuals.

Kelly, a care recipient, spoke of being sexually assaulted by a staff member whilst under compulsory care, demonstrating the most serious abuse of power over an individual. From Kelly's perspective, the service had subjected her to multiple abuses: they had employed a staff member who had assaulted her; they had failed to protect her or even believe her when she spoke out. Speaking of the manager of the service she said:

She should really realise that what goes in the service and it doesn't mean just because the clients are there, it's also, staff gets away with whatever they want. But the other thing is just because they have a disability, that doesn't mean they have to blame it on to somebody else because they've got a disability. That's what the whole story is all about, about a disability. Blame somebody else for their fault.

Kelly shared that she had experienced a lifetime of abuse. This experience reflects the devalued subject position offered by an intellectual disability discourse where a power imbalance creates the opportunity for an abuse of power to occur. Kelly resists the permanently impaired subjectivity and defends her right to be believed:

They should realise themselves. They know that they don't have a disability but they know that they can bullshit as long as they know what bullshit is all about. Disability or no disability you can both lie it doesn't make any difference.

According to Kelly, because she had an intellectual disability there was an assumption that she has lied about being abused. An intellectual disability discourse has positioned her as unable to self-advocate or even to have a level of understanding of what had happened. She was viewed as lacking credibility, in the first instance by the service and later by the police and legal system. She also believes that due to the staff member not having an intellectual disability, it was assumed that he was telling the truth. She made the

point that lying is something that all people can do — disabled or not. Kelly had been abused by the individual and further abused by the unequal power relationship that elevates the staff member above her.

Summary

As stated in Chapter Three, on a very explicit level the IDCCRA was a mechanism of social management to address offending behaviour by care recipients. The IDCCRA was only available for those who have been given the appropriate diagnosis. With the provision of a diagnosis of ‘intellectual disability’ the IDCCRA is provided as a diversionary system away from the criminal justice system into the disability support system (Brookbanks, 2003). It was both the intellectually disabled offender’s ‘permanent’ impairment and their perceived vulnerability that prompted a different response.

In this chapter I have identified the deployment of a medically driven intellectual disability discourse that positioned care recipients as permanently impaired and child-like, hence vulnerable and ‘risky’ subjects. I have also identified that this discourse has been dominant as it was reflected both in the parliamentary debates in 1999 and 2003, and more recently in 2010 in the current study.

Such constructions have very real effects for care recipients. They were positioned as powerless in relation to service providers, who were constructed as parental and having decision-making authority over all aspects of their lives. The power imbalance between care recipients and service providers had the potential to become abusive. Discursive practices deployed by the intellectual disability discourse focused on meeting only the care recipient’s functional support needs. There was limited focus on community integration and what was

considered by participants to be effective rehabilitation. At the same time care recipients were subject to another discourse that positioned them in relation to their criminal offending.

CHAPTER 6 – THE CRIMINAL DISCOURSE

Introduction

In this chapter I examine the way that care recipients as intellectually disabled offenders have been discursively constituted under the IDCCRA by a criminal discourse. Using the words of the participants, I explore subject positions such as ‘criminal’ and ‘risky’ offered to care recipients and the notion of ‘doing time’ that was a result of an approach focused on containment and risk management. Identities were analysed to identify the discursive processes and the resultant power relationships for care recipients and service providers. I also argue that a criminal subjectivity may be a new one for some care recipients, whose behaviour would have been constructed very differently prior to the IDCCRA being in place. Prior to the IDCCRA they would not have been charged. With the IDCCRA being available and charges being laid, behaviour was constructed as criminal. In effect, the IDCCRA has allowed for new identities to emerge.

Particular focus will be given to the techniques of disciplinary practice as service providers seek to modify the behaviour of care recipients to match that of non-offenders. I also show how the disciplinary processes of normalising judgements, surveillance and regulation of time and space all serve to ‘train’ the care recipients. Like the intellectual disability discourse, the criminal person discourse has the effect of shutting down rehabilitation that focuses on community integration. In this case I argue that it was due to the construction of care recipients as dangerous and in need of containment.

Placement under the Act

Once a decision was made to place an individual under the IDCCRA, individuals were described as ‘care recipients’ by their court order. They were placed in specifically

contracted residential services under compulsory care via either a ‘secure’ or ‘supervised’ order. Both orders require a twenty-four-hour level of supervision for the duration of the order (Ministry of Health, 2013). As stated by Walter, a service provider:

Once compulsory care order is made [in] the district court or the high court, then the person is required to live as directed by the care coordinator and the person is required to move immediately into the facility designated as the place to serve the compulsory care order.

As described in Chapter Three, care recipients under a secure order were placed in either a secure community placement or in a hospital-level secure setting and subject to a greater level of restrictions. In these settings care recipients were under a constant level of supervision during waking hours and may have been subjected to regular checks during sleeping hours. They were unable to leave the premises unless via approved leave by their care managers and in some cases from the Director General of Health. Under a supervised order, compulsory care was only provided in a community residential service. Regulation of space was a significant strategy of disciplinary power practiced in the compulsory care setting.

Subject Positions

Criminal Person

As explained in Chapter Three, the IDCCRA was developed to provide an alternative pathway to that of prison for intellectually disabled offenders. The Act was intended to both meet their disability support needs and address any criminal offending behaviour with a goal of community reintegration (Duncan, 2013).

Entry into the IDCCRA required potential care recipients to have committed a criminal offence. This means that they must have engaged in what constitutes offending behaviour, have been charged by the police and required to appear in criminal court. If they had a known intellectual disability, or court staff suspected they may have an intellectual disability, individuals were then assessed to determine a) whether they meet the criteria for intellectual disability, and as an outcome of this assessment b) whether they should be placed under a prison sentence or compulsory care under IDCCRA as an alternative to a prison sentence.

A criminal discourse establishes a particular version of 'truth' in relation to care recipients as 'criminals' that appears 'natural' and 'normal' due to their engagement in the criminal offending that brought them under compulsory care. As a result, care recipients were considered dangerous based on their potential to do 'harm' to individual victims and/or to general society in terms of breaking the law. As stated by Whitney, a service provider:

Generally it's around functioning with society and there are rules about how we conduct ourselves with each other.

A care recipient may have taken on a criminal identity or have had it imposed on them. As a result, care recipients were considered at risk to themselves and/or others. Whilst risk was based on both their actual and potential 'offending' behaviour, it also became part of their identity as they were constructed as criminals in need of 'disciplining' to prevent future offending. For some care recipients, behaviours of 'risk' had been constructed very differently prior to involvement in IDCCRA. Darcy, a service provider, spoke of a specific situation:

Look back through their notes and there's been a hundred other times when they've belted [someone while] in care or something's happened and they've never been charged with those offences before and once the legislation came in, they were charged with doing exactly the same behaviour which two years before they'd done and not been charged with.

What Darcy identified was that following the Act there was a different response to the behaviour of people with intellectual disability, which was now labelled as 'criminal'. The person with an intellectual disability was now charged by the police, required to appear in court, go through an assessment process and placed under compulsory care. With the Act coming into being, a new subject position was created for people with intellectual disability.

Harry, a care recipient, drew on a criminal subjectivity and, in positioning himself as such, argued that he'd be more appropriately placed in prison and stated:

Nah. Mum and them so didn't want me to [go to prison] aye, they were like oh you wouldn't be able to handle it in prison. It was like, you want to bet? I could have cracked it in prison.

Harry also resisted the 'permanently impaired' subject position imposed on him by intellectual disability discourse and saw the resultant attention to disability support needs as overly restrictive:

Yeah it felt like prison. I actually would have just rather stayed inside and done my time in there. Yeah, because I knew, knew a few guys inside and I didn't know anyone when I came into [service]. And then one of the boys came out of prison and it was like, hi, we meet again.

A criminal subjectivity had very real effects for care recipients. Walter, a service provider, compared care recipients with others who had similar behaviour that had not resulted in compulsory care:

Because they've been charged and placed as a care recipient and then exited, [care recipients] appear more risky than a person who has similar offending or similar assaultive behaviours who has simply not been processed through the justice system.

Those who had been charged and marked as criminal had become more highly individualised and were perceived as being at an increased level of risk. Interestingly, in many cases the offence had occurred in a residential setting, and the service provider had involved the police, resulting in charges for the individual. I suggest that good behaviour-management strategies on the part of the service provider might have prevented the need for police involvement.

The above excerpt reflects that the impact of becoming a care recipient and the resultant criminal identity has a very real material impact and may provide a barrier to reintegration into society. This was further demonstrated by Whitney, a service provider:

Some of the guys are really unrealistic, guys that have a criminal history, or any offending, in particular sexual offending. The bottom line is ever getting a job, regardless of whether they've spent time with us or not, is significantly reduced. When talking to them all they want is real work and sometimes you feel like saying 'Buddy you've got to get in the real world here. You've already stuffed that one up in a big way. And that's got nothing to do with the fact that you happen to be living in a service, that's you know way before this. So the fact that you know the guys have got a criminal history absolutely it's going to have a significant impact.

For Whitney, placement under compulsory care produced very real effects for care recipients. As a result of committing a punishable offence, they were considered less employable based on perceived risk by potential employers. Whitney makes a clear link between offending behaviour and not getting employed.

Person “Doing Time”

The notion of care recipients ‘doing time’ was described by Walter:

Some of them will see it as I quote, ‘like doing time’ and they do not perceive any change at the end of the process other than the fact that they might get a roof over their head and they might get a feed but when they are bored and they’ve got use of alcohol and drugs, they simply go and reoffend again. (Walter, service provider)

Walter identified that the idea of doing time provided a limit to the level of engagement by the care recipients and he believed that this increased the likelihood of them engaging in offending behaviour following release. Here a custodial subject position was evident for service providers, who were considered to be containing the care recipient solely. This was also stated by Whitney, a service provider:

Unfortunately they [care recipients] do view it as doing their time and they work really, really hard to keep their nose clean. That’s not creating the easiest environment for us to do rehab work because they’re just putting on a bit of a façade and it’s not until critical events happen that we get to see the true selves and you know it doesn’t happen in prison does it? If I got a 12 month sentence in prison, there’s diddly squat that I have to do to get out at the other end of it.

Whilst there was a level of docility and conformity demonstrated by the identified care recipients whilst under compulsory care, this did not translate into long-term change in

terms of a reduction in the potential for further offending. The care recipient had no agency or speaking position other than as deviant, and can only demonstrate his or her docility within the limits of the criminal discourse and containment within the service that was provided by compulsory care.

Above, Whitney noted that a care recipient may no longer demonstrate the offending behaviour as long as they were under their 'sentence'. As Paul, a care recipient, described, his order was an "eighteen-month sentence". The nature of compulsory care and containment within the service provided withdrawal of freedom and a physical limit to their behaviour. Compulsory care was understood as punishment for the crime they had committed, much like that provided by a prison sentence. The concept of doing time placed a finite term on the process of punishment, with the apparent possibility of care recipients returning to offending behaviour following release. As a result, care recipients see themselves as 'doing time' as stated by Darcy, a service provider, in a:

Kind of a mix up about doing time versus doing rehabilitation.

This provided a limit to both their engagement in rehabilitation programmes and the improvements that they were able to achieve.

Punishment was described by Foucault as "The Punishment and correction that it must operate are processes that unfold between the prisoner and those who supervise him. They are processes that effect a transformation of the individual as a whole" (Foucault, 1977a, p. 125). In Foucauldian terms, punishment is a means of disciplining a care recipient through the withdrawal of freedom for a specified period of time in order to modify their behaviour.

Discursive Processes

Discursive processes reflect the way in which a criminal discourse was deployed. Such processes were the means by which discourses were given meaning and force. Discursive processes were a device through which knowledge about the criminal was developed and the subject constituted in terms of how care recipients understood themselves and became 'made subjects'. As described in Chapter Five, the process of individualising served to highlight points of difference, both bringing the person into view and marginalising them through normalising judgements.

Normalising Judgement

Processes embedded in the IDCCRA require the gathering of information and the assessment and categorising of behaviour against specific criteria. Foucault referred to 'examination' which "establishes a visibility through which one differentiates them and judges them" (Foucault, 1977a, p. 184). Ultimately, these processes were intended to assess the risk of reoffending, and as such reinforced the criminal identity. In this way care recipients became more highly individualised. It allowed for them to be categorised in terms of risk and organised in terms of placement. Normalising judgement was one of the key strategies of disciplinary power. Through disciplinary power a care recipient may become an:

...obedient subject, the individual subjected to habits, roles, order, an authority that is exercised continually around him and upon him, and which he must allow to function automatically in him. There were two quite distinct ways, therefore, of reacting to the offence: one may restore the juridical subject of the social pact, or

shape an obedient subject, according to the general and detailed form of some power.
(Foucault, 1977a, p. 129).

Darcy, a service provider, described the assessment processes used during entry into the Act:

I see my role as being to provide an independent assessment of their, a formulation of their, their mental state and, and their psychological factors that may contribute um, to the offending, or to the risk of future offending. And to um, offer an opinion in relation to rehabilitative or treatment needs.

As a health professional, Darcy was assessing individuals to establish whether they met the criteria for intellectual disability and whether their risk was such that compulsory care was required. Assessments must be conducted by 'specialist assessors', who are deemed to have the appropriate level of training and ability. Specialist assessors are psychologists or psychiatrists who have been designated by the Director General of Health to fulfil their duties under IDCCRA.

Behaviours of risk are assessed against behaviour that was considered 'usual' conduct within society. These normalising judgements have the power to determine the outcome of the court process for the offender. The more the individual is considered to transgress, the greater the perceived need for control. Also, a classification of crimes was expressed, with more serious crimes receiving a higher degree of restriction and punishment. Darcy, a service provider, problematised this classification and said:

We deal with people by the outcomes rather than by the intention. You know, a punch which doesn't kill somebody may have been much more deliberately intended than the person who punched and killed may have been somebody who had been

momentarily panicked, has had some work on their panic disorder and no longer has panic attacks and no longer is going to lash out and may be much less risky than the person who deliberately waited their opportunity and belted somebody but happened not to kill them apparently so. So the outcome may be severe without the underlying cause or intention being as severe. So somebody who has got a really bad crime against them will be generally dealt with as requiring longer periods.

What Darcy's quote demonstrates is that the process of classifying people was problematic and that the issue of intent was not given full consideration. The behaviours were being constructed as criminal in terms of their outcome: the more severe the outcome, the longer the term. If care recipients were unable to decrease the level of *perceived* risk, their release from the IDCCRA remained problematic. Darcy emphasised the importance of risk as a justification for compulsory care:

The primary issue that drives a recommendation to come off or to extend an order on the end of an order is risk. You're um impacting on their total freedom to do what they want and, and in order to justify doing that I think you do have to have some rationale of risk and either to themselves or to others.

In the absence of being able to clearly define the risks presented by care recipients, continuing compulsory care may breach the rights of care recipients. Whilst under compulsory care, care recipients were not only removed from the community into a service, but also a number of strategies were utilised by service providers in the interests of disciplining the care recipient. Once the care recipients demonstrated the behaviours of a good citizen, the perceived risk of the individual reduced. Living in the community requires abiding by the rules. Once these rules are transgressed, the individual is considered in need of disciplining through punishment and control. Foucault (1977a) articulated an historical

shift from the deployment of sovereign or ‘top down’ power, with threats of physical punishment and public torture, to what he describes as a more efficient and productive form of power — disciplinary power. Tremaine (2001) stated the following:

Disciplinary practices enable subjects to act in order to constrain them
 ...Concealment of these practices allows the naturalisation and legitimisation of the discursive formation in which they circulate. ...These seeming acts of choice (limits of possible conduct) on the everyday level of the subject makes possible hegemonic power structures. (2001, p. 622).

Disciplining, in a Foucauldian sense, relates to a process of enacting power strategies that will train care recipients to conform to usual and acceptable forms of behaviour in the interests of becoming a good citizen (Foucault, 1977a). Practices that serve to discipline care recipients, such as the rules of the service provider, limit their conduct through regulation and routine.

Containment

Compulsion was considered necessary to create the change for care recipients to be considered ‘safe’ and to regain their freedom. Placement under the Act was a very clear and specific removal of freedom. As stated by Walter, a service provider, in respect of the order ending, care recipients were required to demonstrate:

That the risk to the community and to the person is minimized and their offending behaviours which has seen them go through the courts or seen them referred by prison to IDCCRA have been addressed to a point that the person is believed to be safe to come off the compulsory care order.

Drawing on a criminal subjectivity, Sara, a service provider, spoke of a care recipient as only conforming to the required standards of behaviour whilst under compulsion, reinforcing the notion that containment was necessary for conduct to be modified:

I guess [he didn't] have the strength of character or the ability to be able to hold with what underneath it all he knew was the best choice for him. Which is quite sad so you know do you judge whether he was rehabilitatable or not? Under compulsion I'm great, not under compulsion goodbye. And I'll do my own thing and I'll be aggressive and I'll do my solvents and I'll have alcohol and roll on, roll on, roll on.

This care recipient was considered by Sara as incapable of moving beyond the criminal subjectivity. Like a prison sentence, compulsory care was considered necessary to prevent him from offending due to an inherent deviancy or character flaw. Containment related to the controls in place for this care recipient, either by way of a secure environment or the constant supervision provided by staff.

Mary, a service provider, shared her concerns regarding the containment provided by compulsory care:

It doesn't sit comfortably with me that we might have people, you know have this as a very serious consequence or outcome to offending and say that we're providing care and rehabilitation when actually all we're doing is providing containment ...because for some of those people they'd be better off going to prison and getting out after two years and carrying on with their lives because you know the reality is that they get trapped in a cycle where they have very little power to change things.

According to Mary, the limits provided by a model of containment represented a problematic option for care recipients whom she considered may have been better off going

to prison. Mary's view was that a custodial model provided an over-focusing of supports on risk management and containment rather than strategies related to reduction in offending that would aid community integration.

However, care recipients were not always passive 'recipients' of power relations that acted upon them. According to Foucault (1977), individuals actively constitute and recognise themselves as particular subjects, give particular meaning to their conduct and limit their conduct accordingly. One care recipient, Neil, took on the criminal identity and contained his own behaviour beyond what was required by his compulsory care order. He stated:

Yeah because I can't, I can't really stay, stay with them [certain family members]. So whenever see one of my I've got to make some kind of excuse, some way out...because I can't really tell them what I really done so I've got to make some lies telling them this because this got to keep them safe and keep me, keep me safe otherwise one of us may go to the hospital...Lousy.

Neil regulated and limited his own conduct based on his recognition of himself as a criminal subject, with the implication that he was dangerous to his family. He believed that if he spent time with his family, he was putting them and himself at risk of further offending. This was despite him no longer being a care recipient and subject to compulsory care. The criminal identity was still very real for him, and his potential for reoffending was experienced as enduring. This could also be seen as the effects of surveillance, which will be discussed later in the chapter.

Regulation of Space

The location of care recipients in particular spaces was another demonstration of disciplinary power enacted through a criminal discourse. Initially, many care recipients were placed in relatively secure environments whilst observation and assessment was conducted to determine the level of risk. With knowledge and understanding of the person came a reduction in perceived risk. As stated by Walter, a service provider:

Thus the person may require a secure environment initially because they may be unhappy that they've been placed under compulsory care or the risks were deemed high and there needs to be a general understanding as to how best to support the person at the time. And with progress [there can be a] relaxing of the levels of security around the person which was seen as the pathway to rehabilitation.

When entering a service, care recipients sometimes demonstrated their resistance in aggressive and/or problematic ways. As the service providers got to know care recipients better, they were able to implement strategies to help care recipients manage their aggressive behaviour. More secure environments provided a greater ability to both limit conduct and withdraw freedom for care recipients. As stated by Paul, a care recipient:

Oh the staff at [the supervised level service] are pretty good compared to [the secure level service]. Because they let you do things on your own. Not looking over your shoulder making a cup of tea or something like that.

While in a secure service, Paul was the subject of surveillance and was watched by staff at all times during his daily activities. He noticed a significant difference when moving to a supervised-level service.

Another care recipient, Harry, compared his life prior to the IDCCRA in a mainstream residential service to life under compulsory care. Harry said:

Oh just everything was just like, you know, freedom. You just could come and go as you please. Like you couldn't come and go as you pleased but you could if you wanted to, you know what I mean? It wasn't, you weren't locked down 24/7, yeah.

This concept of 'lockdown' was echoed by Paul, another care recipient, who used this description in relation to particular houses which to him meant:

You can't go anywhere or do anything.

Paul identified that placement in different houses provided different levels of security. In reality, this meant that some houses had environmental security measures such as lockable doors, window grilles and alarmed doors. Care recipients could be relocated to lockdown houses based on 'bad' behaviour.

In this way the space within which an individual was placed becomes an indicator of behaviour or progress, and they were able to compare themselves to others. Less secure environments accorded greater community access and freedom as a reward. As stated by Foucault, "the disciplinary apparatuses hierarchized the 'good' and the 'bad' subjects in relation to one another...Discipline rewards simply by the play of awards, thus making it possible to attain higher ranks and places; it punishes by reversing this process" (1977a, p. 181).

As reflected by Paul and Harry above, the environment they were in at a given time was a reflection of how their behaviour was perceived at the time. In Foucauldian terms they were rewarded by moving to the less secure environment. In the same way, moving from a less secure to a more secure environment can be seen as a strategy of Foucault's notion of

the practice of punishment. Hannah, a family member of a care recipient, described a situation in which it was suggested by her daughter's lawyer that her daughter be placed in Mt Eden prison as a means to 'teach her a lesson' following her engaging in several assaults on staff. Hannah stated:

So, you know at one stage they wanted, the lawyers wanted to have her put in [prison] for a fortnight as punitive justice to teach her a lesson.

This demonstrated the enactment of punishment as a discursive technique and disciplinary power to create a more docile subject. A criminal discourse provided punishment as a discursive practice and applied a technology of power that was intended to discipline through the withdrawal of freedom and the placement of restrictions around many aspects of daily life for care recipients.

In terms of disciplinary power, movement from a more secure environment to a less secure environment resulted from a greater level of docility on the part of the care recipient whose behaviour was viewed as conforming as an example of reward. Both environments were located in the community but, as detailed in Chapter Three, had distinct levels of security. As described by Walter, a service provider:

Progress through to supervised maybe a relaxed amount of supervision not having a one on one staff dedicated to that person, throughout the day. Being allowed a lot more leave in terms of working around the facility or around the house and the gardens and, in their own room. The person may be moved to a facility where there were no fences or boundaries and it could be that the person is then um granted leave to visit family, friends or attend employment as some of them do.

As care recipients progressed through their training programme, their conforming and non-offending behaviour was rewarded with activities involving greater community integration. The ultimate reward was release.

Regulation of Activity

Another strategy of disciplinary practice relates to the control of activities with a timetable and regulation of activities (Foucault, 1977a). For care recipients this was detailed in a care and rehabilitation plan that was signed off by the court at the time they were placed under compulsory care. As stated by Foucault, speaking of a prison, “Life was partitioned, therefore, according to an absolutely strict timetable, under constant supervision; each movement of the day was devoted to a particular kind of activity, and brought with it its own obligations and prohibitions” (1977a, p. 124).

Through this, the prisoner’s physical body was regulated through a timetable and schedule of daily and weekly activities. Harriet, a service provider, spoke of the process of developing a care and rehabilitation plan for a care recipient:

Then starts the process of getting to know the client. Seeing how that care and rehab plan was transcribed through to the day to day rhythm and routine. How do we look after this person on a daily plan? I’m arranging to work out in terms of within the routine and within the provision of the unit, how can I get this person out on a Wednesday out to their art class? Now if I can’t do it on a Wednesday, what day can I do it? So it’s about marrying up what has been prescribed, within the resource and the rhythm of the unit. [It means] constant assessment of it on a day to day basis on a week to week basis.

Harriet described the implementation of the care and rehabilitation plan as fitting into the 'rhythm and routine' of the unit with a negotiation between the needs of the individual and the overall regulation of activity. According to Foucault, "The timetable is an old inheritance...Its three great methods, establish rhythms, impose particular occupations, regulate the cycles of repetition" (1977a, p. 149). Activities of daily living such as getting out of bed, having breakfast, showering and attending daily activities were all detailed in the care and rehabilitation plan and monitored by staff in terms of what would be considered usual and acceptable. Generally, care recipients would be expected to get up and have breakfast around eight o'clock and then attend a range of vocational and therapeutic activities throughout the day.

Standards of conduct were imposed on care recipients in terms of achieving certain goals. This was described by Neil, a care recipient, who talked about his care and rehabilitation plan in the following way:

Yeah they have our plans and we have a meeting with [the care manager] what we're going to do for the month, every year or something like that. Yeah you've got to do your goals.

Goals involved demonstrating improvements such as a reduction in incidents, attendance at life skills and vocational programmes and demonstrating greater levels of independence around self-care. Care recipients were rewarded or punished in terms of how they met the 'ideal', i.e. the more they demonstrated non-offender behaviour, the more freedom they gained. Conversely, where they did not demonstrate improvements, they could be punished. As stated by Harry, a care recipient, if he did not comply with the regulated activities, "Oh they just you know stopped me like going out and doing things like that".

According to Foucault, punishment becomes an everyday apparatus that affects everyone, not just offenders but also those individuals who enforce the punishment:

The order that the disciplinary punishments must enforce is of a mixed nature: it is 'artificial' order, explicitly laid down by a law, a programme, a set of regulations. But it is also an order defined by natural and observable processes. (Foucault, 1977a, p. 179).

Care and rehabilitation plans were required to be written by staff, reviewed on a regular basis and reported on. What this demonstrated was a process of disciplining. The service providers were also regulated in their activities. Whitney, a service provider, shared frustration regarding the amount of paperwork that the IDCCRA generated and stated:

Oh you know it's the chasing up of the weekly planners and stuff like that that have to be done, leave stuff. I think just the complexities of the, IDCCRA group and the administration stuff that goes with it alone is quite significant and people get bogged down here in paper.

On a very visible level, staff were required to supervise care recipients twenty-four hours a day. When engaged in unsupervised activities, such as family visits, care recipients were considered to be 'on leave'. Regulation of activity allowed for the conduct of care recipients to be directed towards non-offending activities.

Surveillance

Regulation of space and time allowed for a greater level of surveillance of care recipients. It was expected that service providers would know where care recipients were at any given time. As described in Chapter Three, Foucault explored the enduring effects of surveillance through the analogy of the Panopticon (Foucault, 1977a):

The major effect of the Panopticon: to induce in the inmate a state of conscious and permanent visibility that assures the automatic functioning of power. So to arrange things that the surveillance is permanent in its effects, even if it is discontinuous in its action ...that the inmates should be caught up in a power situation of which they themselves are the bearers. (1977a, p. 200).

Surveillance was viewed as a primary mechanism to ensure that care recipients did not reoffend. Service providers were given the role of implementing discipline and punishment through care and containment. Bleasdale (2011) discussed surveillance in regard to disability support services in Australia and said, “This more gentle form of surveillance is provided, in the main, by the paid staff of services who again are charged with the task of training, or guiding, or implementing programs, but who also maintain that custodial function” (2011, p. 11).

Panopticism was not confined to prisons but employed throughout society. Panopticism enables the emergence of new forms of knowledge borne out of observation and assessment as already identified. Panopticism reflects how the subject becomes ‘made’ based on his/her engagement in self-regulation. Care recipients were not only watched, assessed and corrected, they began to correct themselves. In this way all of these processes tie care recipients to their subjective or criminal identity, which ultimately subjects them to a greater level of control (Roberts, 2005).

In the production of knowledge, written documentation was produced in relation to care recipients. Information-holding about an individual became a mechanism in which power was deployed, positioning care recipients in a relatively powerless position where they were not the owners of information ‘about’ them. In response to being asked what rehabilitation is, Paul, a care recipient, said:

Ah yeah it's a thing where they keep all my file keep a file and one of those ledger books.

Another care recipient, Harry, described very different experiences prior to and after release from compulsory care. Whilst under compulsory care, he spoke of records being kept about him and written paperwork being shared in a manner that made him feel as if information was being stored and withheld from him. He said:

Some things that they brought out they like, would go into the folder and they would pull the paper out instead of bringing the whole folder. It's like, you know, you can only have this and you can only have that, you know. They kind of held a few things back from me. Of things I needed to know yeah. But I mean if I needed to know I would have asked them but it was like, didn't want to bother it was just too much hassle. It just felt stink aye. But when the, but when they did sleep over I used to always pull my folder out.

Harry identified that he could ask to look at his notes but was afraid to do so as staff had reacted negatively to requests in the past. His strategy was to wait until service providers were asleep and then look at his file. Harry described the support he received following release from compulsory care very differently. He stated:

It was like I was getting informed all the time of what was happening and things like that. I was getting more informed when I was off it than when I was on it.

Harry's excerpt demonstrated that the tactics engaged in by the service provider were very different whilst he was under the Act and identified as a criminal. Once he was no longer subject to the criminal discourse and viewed as a criminal, he was allowed a greater level of freedom, engagement in decision-making around his life and sharing of information.

He was given a greater level of autonomy, and some of the limitations that had previously been in place were removed.

Another care recipient, Ted, spoke of different surveillance practices by staff prior to and following release:

Like before (when) I was under the Act the staff was always watch me and supervise training and I felt embarrassed. All the boys were saying who's that? I'd say oh I don't know. I think they thought he was my driver.

Ted was attending rugby training and whilst under the IDCCRA had staff supervise him. Ted was embarrassed by staff whose presence indicated a level of untrustworthiness. He was marked as different from the rest of his team, who did not have someone keeping watch on them. Following his order ending, he was allowed to attend on his own, surveillance practices were no longer in place, and he said:

I'm free man now, I just do the bus by myself and bus to Framework and bus back home.

For Ted the effects of surveillance were very real whilst under the Act, and his sense of freedom in being able to behave as he desired following release was very evident.

Summary

A criminal discourse produced 'criminal person' and 'person doing time' subject positions for care recipients. Such subject positions had real effects for care recipients in terms of employment and the ability to live in the community following release. This meant that the disciplinary strategies had been successful. Placement under the IDCCRA provided a very specific withdrawal of freedoms for care recipients.

Strategies of containment and disciplinary power were dominant in the implementation of the IDCCRA. Disciplinary power was evident through the control of space, activity and daily life as strategies to normalise the behaviour of care recipients and provide the necessary containment in order to prevent further offending. The notion of doing time had the effect of limiting the engagement of care recipients in rehabilitation, which meant that lasting behaviour change was less likely to occur. Behaviour change related to offending behaviour that had brought them under the framework in the first place. Rehabilitation with a focus on education and skills development was rendered invisible, with care recipients being constructed as risky and in need of control and containment.

CHAPTER 7 - THE CAPABLE PERSON DISCOURSE

Introduction

In this chapter I identify a counter discourse which constructed the care recipient as capable. I have called it the capable person discourse. A capable person discourse countered the permanently impaired and criminal constructions offered by intellectual disability and criminal discourse described in Chapters Five and Six, and provided an alternative understanding of intellectual disability and offending behaviour for care recipients. I argue that this counter discourse constructed care recipients as being capable of having an 'ordinary life'. As mentioned in Chapter Two, the United Nations Convention of the Rights of Persons with Disability has an emphasis on creating change to facilitate the inclusion of people with disability in a manner that situates disability as an expression of human diversity (Chan et al., 2012). By attempting to foreground a capable person, the Act was contextualised within broader disability imperatives such as inclusion and dignity.

As a counter discourse, a capable person discourse positioned care recipients with agency, able to engage in the rehabilitative process in a meaningful way. Discursive processes enacted through a capable person discourse positioned them in an equal relationship with staff rather than as childlike, voiceless and deviant. Care recipients became more than criminals and intellectually disabled individuals. Rather, they were constructed as able to become contributing members of the community as a result of the support they had been provided under compulsory care.

As equal community members, care recipients were considered entitled to freedom from discrimination and abuse. They were also entitled to supports that would provide the

best outcome in terms of reintegration. The best outcome was one that demonstrated their position as valued community members.

Discursive processes involved education and training provided by service providers. Service providers were constructed as educators and facilitators. Rehabilitation with a focus on community integration was brought into focus by a capable person discourse. This was in contrast to rehabilitation being rendered invisible through the custodial and risk management approach provided by the criminal discourse and the permanent impairment and vulnerable subject positions offered by an intellectual disability discourse.

The Social Model Discourse

The ‘capable’ discourse was aligned with, and I suggest draws on, a social model discourse. A social model argues that society’s failure to adequately ensure the different needs of disabled people are fully accounted for in its social structure provides a barrier to full participation for disabled people. Further, the consequences of this failure do not simply fall on individuals but systematically upon disabled people as a group, who experience the failure as institutionalised discrimination (Barnes, 2003; Winance, 2007).

Societal understanding of disability has been significantly informed by a medical model as discussed in Chapter Five. A medical model focuses on the limitations provided by impairments that are located within the individual. According to the medical model the consequence of such impairment is a disabling effect as the individual cannot engage in society in a ‘normal’ manner. A medical model defines ‘treatment’ as the means to restore a disabled individual to normality (Barnes & Sheldon, 2007).

The social model arose out of disabled people's critique of the medical model. Specifically, the assumptions the medical model made regarding normality, the location of disablement within the individual and the lack of recognition of disabled people's expertise in their own experiences (Barnes & Sheldon, 2007). The social model seeks to redefine commonly accepted theories of disability and instead draw on the experiences of people experiencing disabilities themselves to provide understanding (Munford & Sullivan, 1997).

Disabled people are constructed as both capable of having a voice and defining their own experiences. The voice of disabled people was demonstrated by a collective of physically disabled people called the 'Union of the Physically Impaired against Segregation' in 1976. The group defined impairment as "having a defective limb, organ or mechanism of the body" (UPIAS 1976, p. 3). Disability was defined as disadvantage caused by society where the needs of a group of individuals who had impairments were not considered resulted in exclusion from participation in society (UPIAS 1976, p. 4). The result of the separation of impairment and disability was that a causal link could not be assumed and consequently disability is viewed as a social construction (Barnes & Sheldon, 2007).

Society's insistence on segregation in education and services, and the inaccessibility of transport and buildings, results in a general prejudice against an integrated community life for disabled people. The nature of their disablement comes from a non-inclusive society that is structured to exclude them (Barnes, 2003). The impact of which has been said by Wolfensberger (1994) to create a culture of dependency and 'death making', a process whereby people are made invisible, socially oppressed and symbolically dead (p.3.).

According to the social model, impairment is not in itself a problem, even though it may produce a need for a different set of living requirements. The social model of disability does not exclude interventions and support mechanisms but argues these must never take the place of social change to facilitate inclusion that is meaningful and the pursuit of an 'ordinary' life (Barnes, 2003). The social model provides a framework of values for services to integrate into their daily practice. At the core of the social model is the understanding of disabled people as being capable.

Subject Positions

The Capable Subject

The counter discourse offered a capable subject positioning to care recipients. As such, care recipients were imbued with capability. Capability related to the ability of individuals to learn and engage in everyday activities and make a contribution to society. Capability also related to the ability to cope with and move on from negative life experiences.

For example, Darcy, a service provider, described what she called resilience in individuals who had demonstrated the capability to move on from abusive experiences:

I guess the single thing that is apparent, almost universally, with them is how horrible their lives have been, they're people who have been multiply stuffed by everybody and every system all the way through their lives almost invariably and yet they're often not sad people either. So I'm often impressed by the resilience of them to have survived through things that I think, I'd just be a gibbering wreck in the corner.

Darcy compared these individuals to herself in terms of the strength they had shown in dealing with experiences of abuse. As I have proposed in Chapter Five, being subjects of the intellectually disabled discourse may construct care recipients as more vulnerable to abuse, as exemplified by Kelly. As detailed in Chapter Two, much has been written about the abuse of disabled people that indicates both a level of vulnerability to abuse from family members and other individuals in support roles, and a level of tolerance demonstrated by society (Roguski, 2013). The New Zealand research by Roguski (2013) described the frequency of abuse experiences as being driven by pervasive devaluing of disabled people within society. Instead of further devaluing these individuals, Darcy identified them as capable. She described them as strong; survivors of traumatic experiences who had moved on with their lives.

Darcy also positioned care recipients as capable subjects by noting and celebrating the success of care recipients following their release, saying:

Often you get to see them again, over time and that's really exciting as well because for many of them you do see progression and change and improvement and you see them getting sorted and that's heaven.

From a social constructionist point of view, societal context was significant in the construction of care recipients. Rather than viewing these individuals in terms of their individual characteristics and limitations, Darcy signalled the importance of their social, environmental and experiential context to their offending, indicating that if the intellectually disabled person's environment was changed, for example through nurturing and support, their offending behaviour had the potential to change.

Emerging Subjectivities

With the provision of a different environmental context, alternative subjectivities were allowed to emerge. This was particularly true of an emerging group that Darcy, a service provider, identified:

I've noticed that the type of care recipients that we are getting is changing. They're more streetwise. A lot of them have had access to drugs and alcohol from a very early age. Their developmental years haven't been the best. I think in terms of your genuinely intellectually disabled person, who initially I thought the Act would be used for, we're not really seeing that sort of person come through because really mainstream services are able to provide services for those people.

Darcy differentiated between two categories of people with intellectual disability. The first she labelled as 'genuinely' intellectually disabled, drawing on a medical discourse of intellectual disability in which individuals have been diagnosed in their early years due to birth, chromosomal and medical issues. The second group she identified as being able to 'pass' as 'normal', having developed the ability to cope in a range of different situations; for example, communicating the impression that they understood in a way that others would be able to. These were young, streetwise individuals who due to environmental issues had developed intellectual disability and who were now being identified through the criminal justice process. According to Darcy:

The difference between, is just colossal, it's unbelievably, unbelievably different.

The latter group was considered as having more capability to change their behaviour. What this meant was that the dominance of the criminal discourse had the effect of shutting down any space for those individuals for whom the medical intellectual disability discourse was deployed with the intersection of the two discourses. If they were permanently impaired

and identified early in life, then it was likely that they were not constructed as having the same ability to improve as those were identified as having an intellectual disability later in their developmental years.

The Potential Subject

A capable person discourse constructed care recipients as having the potential to change. Darcy, a service provider, identified that with some maturation and change of environment, the emerging group of care recipients identified above had the capability to decrease offending behaviour substantially:

Sometimes it's just about holding because sometimes it is about maturation and age so if you hold tight until they can get past the non-frontal lobe period of adolescence, then actually the risks fall off very quickly, so sometimes all you need to do, is give people a chance to grow up and learn some rules and get some care consistently over time. Keep them off drugs and alcohol. Sometimes all you need is just somewhere safe to be. Not get yourself killed or in prison in the interim.

Darcy talked about the supports provided under the IDCCRA as 'holding tight' in terms of providing structure and stability to these young individuals. They were subject to disciplinary power, with removal from the community and placement in residential services. Processes of disciplinary power such as surveillance and environmental control were offered as useful mechanisms for the defined holding period. In this way disciplinary power was viewed as positive in terms of modifying the conduct of the young person in order to aid their reintegration into the community. Darcy positions them as having potential within the IDCCRA environment that they may not have in an alternative environment, such as prison.

The placement of the individual in a particular environment was necessary in terms of any perceived capability for change.

Whitney, a service provider, also spoke of the young group of offenders during her interview. Again, the importance of context was stated for this group, but also the potential for change:

The population does seem to be young men at the moment but those young guys that are going to go back to those families that are significant contributing factors to their risky behaviour ...some of the work is often around you know you are your own person and you can make your own decisions that are in the best interest of you. And every now and again you see these little glimpses where you go oh yay they've got it. But at the end of the day their families are very strong influences.

This was reflected by another young offender who been in prison previous to placement under the Act. For Ted, a care recipient, the experience of being under compulsory care was a positive one and provided a much better experience than prison. He stated:

Oh it's a good thing because you can change your life and deal with gangs and stuff. Gangs aren't worth it you go back to jail. It's good to change.

Drawing on a capable person discourse, Ted saw himself as capable of changing and moving on with his life. In Foucauldian terms, Ted drew on this subject positioning to construct himself as being able to directly change his conduct from that of an offender to an individual who no longer engaged in offending behaviour. He positioned himself as an individual with agency who could move on from his former life with the gangs and create something better for himself, take on new roles and avoid future imprisonment. The change

required placement in services under the IDCCRA rather than the prison environments he had experienced previously.

This was echoed by another care recipient, Harry, who spoke of improving his life under compulsory care. Talking about engaging in criminal activity, he stated:

Learn from my mistakes and you know never to go there again you know what I mean. Never, never think about you know things like that.

Harry identified a process of learning that led to change in his behaviour. In doing so he deployed a construction of himself as being capable of learning. He also resisted the notion of himself as permanently impaired by identifying his ability to change. Harry had experienced limited engagement with disability services during his life and was in early adulthood. Having the ability to learn meant that impairments could be improved upon, and improvements related to no longer engaging in offending behaviour.

Darcy draws on the idea of the capable subject to clearly identify that change had happened for care recipients. The disciplinary processes provided under the Act had enabled care recipients to reintegrate back into life as proper citizens with improved skills. Ultimately, this meant living in the community successfully without engaging in further offending behaviour. Darcy not only noted the potential for change for care recipients but celebrates the opportunity to have experienced it. This was mirrored by Whitney, a service provider, who spoke of change happening for care recipients:

People have walked away with something in their tool box that they do differently which means you know fundamentally if nothing else, they may not get themselves into the same form of trouble.

Care recipients were constructed as having learned and conformed to expected patterns of behaviour. What was also demonstrated was the subject position of educator or facilitator offered to the service provider by the capable person discourse. Whitney established a clear link between the tools care recipients learnt whilst in service with a change of behaviour once they left the residential service behind. The IDCCRA provided a number of new tools for the care recipient to draw upon. The potential was to live an ordinary life just like everybody else.

Ordinary Life Subjectivity

Drawing on the concepts detailed in the *National Health Committee Ordinary Lives Report* (Ministry of Health, 2003b), an ‘ordinary life’ subjectivity relates to a society that highly values the lives of disabled people and enhances their full participation. A capable person discourse positions care recipients as having the capability to be the same as other members of the community. As such they were entitled to same desires as others, such as having a job, relationship and home they could call their own.

Once behaviours were shaped into that of a non-offender, the reward was living a life in the community and having some measure of independence. As stated by Walter, a service provider:

I had a gentleman who was originally under compulsory care for 12 months. After six months was offered full time employment, and the issues that had been affecting him prior to his entry were resolving themselves in terms of his own life. There appeared to be no purpose in continuing the compulsory care for another six months because it would have delayed the family being eligible for a home, for the partner and the children which would have affected his ability to undertake full time

employment successfully. His order was cancelled. He does appear to be living successfully in the community.

The reward for improvement and meeting the norm was the care recipient's compulsory care order being cancelled and the ability for him/her to move home to his/her family. Disciplinary power was again evident in the regulation of space, in that moving out of service and back home was their reward for conforming. A capable person discourse was drawn on to construct the care recipient as having potential, entitled to freedom once their behaviour demonstrated that of a non-offender.

In terms of an ordinary life, he/she was not considered 'special' in relation to others and had the potential to face the problems all people do in terms of family and work life. In the words of another participant, Harriet, a service provider:

An intellectual disability doesn't provide you with a blessed life because you've got an intellectual disability. It provides you with a day to day life in the community, as a member of the community like every other member of the community. And you don't always get what you want.

In a Foucauldian sense, with community integration, care recipients became less individualised, less marked as different and 'normalised' (Foucault, 1977a). An 'ordinary' life and being treated as no different to anyone else was the ultimate reward for care recipients. As discussed in Chapter Six, rewards are at play with disciplinary power in respect of a regulation of space. The move to a less restrictive environment was reward for the improvement in conduct demonstrated by the care recipient. Walter, a service provider, discussed integration at the end of their compulsory care order:

In the community under [a]supported living provider, knowing that the house or the flat they're moving to is going to be theirs, they're seeing a reward at the end of this process, they're not simply walking out the door.

In engaging in the process and disciplining themselves, the care recipient saw the potential for themselves to live successfully in the community. Being able to have support to achieve an ordinary life was cited as key for Whitney, a service provider:

Oh I don't know, something out of the bag, you know, people living in their own communities, being supported without all the rules and regulations and tick boxes that services have you know. Someone that, some, they're still able to make the decisions that they want to make in their life, and someone is there to support and just pick them up.

Again Whitney noted the reduction in need for disciplining of care recipients following release, with the absence of rules and regulations. Given the right circumstances, care recipients had the potential for a better life without all the controls of living in a service. As noted by Walter, a service provider, an ordinary life meant dealing with the same everyday issues as anyone else:

I've cooked, cleaned and looked after myself, I can sit down and I can have a beer and I can watch T.V. I can put my feet up without having to worry about it, I can forget to mow the lawn for a week and not worry that a member of staff is going to upset me because I haven't done my chores for the day. I think that although they're never going to pose no risk of reoffending in the future you're reducing it because they've got something they perceive as theirs.

This quote demonstrates the discursive construction of ‘ordinary life’ of community integration. Walter was drawing on a particular understanding of an ordinary life which he then assumed as being the ideal for care recipients. It also depicts a situation for care recipients in which they decide what they want to do and when to do it.

Service Providers – Educators and Facilitators

As discussed in Chapter Three, the current study draws on an understanding of rehabilitation as “Improvement of the character, skills and behaviour of an offender through training, counselling, education etc. in order to aid reintegration into society” (Duncan, 2013, p. 367). From a social constructionist perspective, power is viewed as productive, with practices that serve to shape care recipients’ behaviour so that they perform or behave in ways that are regarded as the norm. As already discussed in Chapters Five and Six, disciplinary practices work in the name of governmentality, a notion developed by Foucault (1977a) to describe the ways the conduct of subjects were governed. To this end, disciplinary power was enacted for the purposes of training.

Service providers and support staff had responsibility for articulating the manner in which the care and rehabilitation planning and processes were implemented, and as such were constructed as trainer/educator and facilitator by a capable person discourse. The care and rehabilitation provided was focused on change by limiting some behaviours, offending, and growing other behaviours and capabilities that would work towards community integration. This was echoed by Barney, a service provider:

I mean they do the basic, like cooking skills, that’s very handy, but if you can’t teach people how to live with other people in the community, which is obviously a prime

requisite of living in the community if you're disabled, and how to address the concerns that brought you in here the first time.

The above quote demonstrated the underlying belief that care recipients had the capability to achieve more than 'the basics' and in fact were entitled to supports that would facilitate this process. Barney positioned care recipients as capable of achieving more in terms of gaining the skills for successful community living.

Key elements of care and rehabilitative practices were described by participants. The first of these was being strategic, as described by Holly, a service provider:

It's my view that we should be thinking about life after the order very early on in the piece and I think that's something that we need to concentrate a bit more on when it ends and it's kind of like oh what have we done in terms of transition. What have we done in terms of you know encouraging the person to move on to the next step.

For Holly, compulsory care included rehabilitation that offered the care recipient the opportunity to improve and move on with their lives. Her strategic view related to focusing on skills that would create a greater level of independence, rather than strategies that would create a level of dependency such as those deployed by the intellectual disability discourse. She identified dependency as providing a barrier to transition into the community once their order ended.

Holly positioned the move into service as temporary. Instead of looking at what life would be like in service, she looked beyond, planning for what life needed to look like following compulsory care. She saw this as the responsibility of the support staff in partnership with the care recipient.

Thinking strategically involved looking at the specific skills that the individuals needed to live ‘successfully’ in the community. As previously mentioned in relation to the ideal life painted by Walter, success was a notion that was discursively constituted. This involved skills that would prevent further offending. It also involved rehabilitative strategies that would support independent living; everyday skills such as cooking, household management, accessing the community and managing finances that would facilitate less reliance on service supports. Holly positioned care recipients as having the capability to make this happen. She attributed responsibility to the services to ensure the right rehabilitative supports were put in place to make this happen. Providers and care recipients were viewed in partnership, with a relationship based on equality, and care recipients took part in their own goal setting.

Other strategies related to therapeutic goals or coping strategies that would allow individuals to live more successfully in the community, demonstrating conduct in line with other community members. Fay, a service provider, drew upon a capable person discourse; she believed care recipients were capable of doing more than attending therapy, which she saw as sometimes being a “tick box” exercise:

You need a clear process why somebody is being sent to counselling and what they’re hoping to achieve... I think that’s important for the person who is undergoing the therapy and it’s also important in terms of whoever’s going to assess it, was it a successful process, should something else have been done? So I think that’s more than being a legal process, can’t just send somebody off to counselling and two years later there’s still no report without knowing what we’re going to achieve or, I just think having objectives.

Fay expected that therapy would involve clear goals with evidenced outcomes following the processes that were of benefit to the care recipient. Discursively constituted, such goals reflect a social construction of what was a good citizen. She also felt that the achievement of goals needed to be evaluated and realistic to the period of compulsory care and based on the individual's needs:

And that their needs should be realistically addressed so, if they're there for twelve months and they have been assessed to have an intellectual disability then don't go off and get this sophisticated plan that will take seven years to bring to fruition.

Fay placed the responsibility for success or failure not only on the care recipient but also with the provider in terms of providing appropriate care and rehabilitation that involved achievable goals. The care recipient was positioned as having potential and being capable of achieving realistic goals. Service providers were positioned as responsible for facilitating the care and rehabilitative process. Rehabilitative goals related to learning and building skills that would facilitate independence and therapeutic goals that would allow the care recipient to develop coping skills or deal with previous trauma. Once new behaviours were learned, care recipients were able to move on from compulsory care and reintegrate into the community.

Discursive Processes

Maintaining Rights

As discussed in Chapter Two, since the passing of the IDCCRA, the signing of the UNCRPD has had a significant impact on the manner in which disability support services have both thought about and implemented disability supports (Chan et al., 2012). The

UNCRPD places significant emphasis on disabled people having the right to equality before the law (Chan et al., 2012).

According to Foucault, power relations are ever-changing, fluid and context dependent. In any given situation there was no power without resistance, as power can only exist where subjects are free to resist (Foucault, 1980). As a counter discourse, a capable person discourse provides a means of resistance to a criminal or intellectual disability discourse. A capable person discourse also brings the rights of care recipients into focus as equal community members. An alternative power relationship to those enacted by an intellectual disability and criminal discourse was provided for this group by a capable person discourse.

As discussed in Chapter Three, the protection of the rights of care recipients was stated as a purpose of the IDCCRA and was debated extensively by Parliament. Also discussed in Chapter Three, rights debates in Parliament related to two particular areas. One was the inclusion of a non-criminal pathway, in which it was considered discriminatory to effectively detain individuals where charges had not been laid (Dugdale, 2002). The other was the inclusion of the word 'rehabilitation' based on the notion that more than containment should be provided (Brookbanks, 2003). Care recipients were constructed as having the right to the same treatment as other community members in the goal to live an ordinary life. Similarly, they were also positioned as having the right to receive care and rehabilitation that would facilitate community integration.

As described in Chapter Three, lawyers were appointed as District Inspectors under the IDCCRA and had responsibility for monitoring services to ensure that the rights as specified in the IDCCRA were upheld. Drawing on a capable person discourse, clear

expectations were conveyed as to how care recipients were to be treated, and non-discriminatory practices were prioritised. As described by Walter, a service provider:

They [district inspectors] should be making sure that their legal rights were adhered to. Generally looking at whether the legislation and some of the strict conditions of the legislation have been adhered to but also whether their basic general human rights and privacy issues have been adhered to during the time under compulsory care they have a duty to report to the Ministry of Health in terms of any failings or unfair processes or practices used in the IDCCRA.

Discursive processes such as investigating and reporting occurred where it was considered that there was a breach of rights. As described by Fay, a service provider and District Inspector:

And the complaint process in terms of a care recipient's rights; have they been breached, so that can be a complaint from either the care recipient or family or anybody else that is involved in their care. And I also report in terms of any investigations that I do, that all goes back to the Ministry.

All care recipients were allocated a District Inspector who would have an ongoing relationship with them to ensure they were happy with the support provided to them. When asked how District Inspectors viewed care recipients, Walter, a service provider, stated:

Well I suppose [District Inspectors] generally view them as a vulnerable person in terms of whether they are able to make sure their rights are protected. So they often see them as a vulnerable person.

The capable person discourse constructed the care recipient as having a more powerful subject position. They were, however, still constructed as being vulnerable in

terms of the need to have someone advocate on their behalf. District inspectors were also in place to ensure that care recipients, as ‘vulnerable’ individuals under compulsory care, were protected. What this demonstrates is the deployment of multiple discourses, with care recipients being understood as both vulnerable and entitled to rights protection.

Discursive processes deployed by a capable person discourse acknowledged that care recipients were entitled to processes that would ensure equality before the law. Reporting provided a formal and statutory process for ensuring that care recipients’ rights were upheld. Practices that provide a level of surveillance of service providers were evident through the complaints process. Another discursive process that was evident under the IDCCRA was that of advocacy.

Advocacy

Advocacy was the stated intention to support a disabled person and to speak out for them when required. Some care recipients had advocates who would make complaints on their behalf. Barney, a service provider, spoke of being an advocate:

I think we have a lot of roles. The prime role is always to stand with the person who’s got the disability, that’s the first one...if you’re going to be an advocate for someone it needs to be long term and one of the most important things you can do if you can do nothing else is simply to be a witness, so you watch and you listen. And you let them know that you’re there.

The relationship was one of equal power-sharing, with the advocate standing alongside a care recipient and taking a lead from them in terms of the support they needed. Advocacy was defined by Whitney, a service provider, as:

It's very much about the relationship. It's not about anything else you know. I think it needs to be somebody that the person knows and trust and there were parameters and responsibilities in terms of them conducting that role... their job is to support them emotionally and also to ensure that they understand what is happening at any given time.

Kelly, a care recipient, talked about having a support person who she trusted implicitly:

I would say the only person that I've trusted in that service for so long since I've been there is Judy. No-one else. I don't care if it's the big boss up in the office, who gives a damn. But when it comes to Judy she's really with me. I'll stand right next to Judy whatever happens to me.

Kelly not only talks of Judy standing beside her, she spoke of reciprocity in the relationship where she would have stood by Judy in return. An equal relationship was described in which Kelly not only receives support and advocacy but draws on a capable person discourse to construct herself as capable of offering a level of support in return.

Summary

A capable person discourse provides very different social and power relationships to those offered by a criminal or intellectual disability discourse. A capable person discourse draws on a social model discourse that seeks to redefine commonly accepted constructions of disability and instead draws on the experiences of disabled people themselves (Munford & Sullivan, 1997).

In contrast to the criminal subject position offered by a criminal discourse and the permanently impaired subject position offered by an intellectual disability discourse, a

capable person discourse positions care recipients as part of the community. A capable person discourse also constructs care recipients as capable of making a contribution to the community. They are also constructed as entitled to the supports to make this happen. This allowed for a sense of agency for care recipients. It also brings into view the broader disability agenda in terms of the discrimination that disabled people experience in New Zealand and the broader rights context provided by the UNCRPD.

Alongside the subject positions offered for care recipients, service providers were offered an educator or facilitator subject position. This enabled them to educate, support and celebrate the improvements they observed in care recipients. It also created more of an equal and reciprocal relationship, with care recipients having the opportunity to determine their goals and ultimately their future. The capable person discourse opens up new opportunities for rehabilitation under the Act. By clearly identifying oppressive structures that serve to marginalise people with intellectual disability, a space is created for change (Munford & Sullivan, 1997).

CHAPTER 8 - DISCUSSION CHAPTER

Introduction

In this chapter I critically examine my findings within the context of the literature and policy development described in previous chapters. I will detail what has been learnt and the significance of my findings for the ongoing development of the IDCCRA framework (Evans, Gruba, & Zobel, 2011). This chapter will pose that deconstructing the context of care recipients' lives allowed me to identify an alternative subject position for care recipients that constructed them as having the potential to reach their full capability.

The current study aimed to identify and analyse the discourses that were evident in the words of the politicians at the time that the IDCCRA was passed in 2003 and then later in the words of the participants in 2010. By identifying these discourses, the study aimed to reveal the subject positions and discursive practices that care recipients and service providers were subject to and the impact of these on their lives. Identifying discourses that provided alternative subject positions opened up the opportunity for care recipients to move beyond dominant, traditional and marginalising understandings of them as intellectually disabled offenders.

Firstly, I will summarise the key findings as detailed in Chapters Five, Six and Seven. Secondly, I will explore the implications of those findings for both service providers and care recipients in relation to the provision of care and rehabilitation under IDCCRA. Then I will then describe limitations to the current study. Finally, I will make recommendations regarding possibilities for future research, policy, practice and education.

This research examined the experiences of individuals who have become subject to the IDCCRA as described by the 'care recipients' themselves and service providers who

were involved in their lives. A social constructionist methodology was utilised to identify discourses deployed by individuals subject to the IDCCRA both prior to and following release. This allowed for a more in-depth understanding of the multiplicity of meanings that shaped their reality. The research asked the specific question, ‘What are the discourses that come into play prior to and upon release from the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, and how do these discourses construct individuals who become subject to the Act?’ A particular research goal was to identify less dominant discourses within the IDCCRA framework that provided differing and potentially more powerful subject positions for care recipients.

The Findings

The current research is the only research to date that uses the words of care recipients themselves to explore their experiences under the IDCCRA. Literature by Bonardi (2009) and Prebble and colleagues (2013) both noted the importance of including the voice of care recipients to inform the development of the IDCCRA framework. The current research included the voice of a number of care recipients to ensure that any research findings were reflective of their views. Being subject to the IDCCRA provides care recipients with the most direct experience of the systems and processes that were required by the IDCCRA.

Literature such as that by Hayes (2000a, 2005, 2007a) and Talbot and Jacobson (2010) indicated the need for an alternative criminal justice process for people with an intellectual disability. Also indicated was the need for adequate resources to meet the needs of any diversionary system for intellectually disabled offenders. In terms of New Zealand developing a diversionary system such as the IDCCRA, the need for appropriate resourcing was indicated early on by Dawson in 1997. Eleven years on from the IDCCRA being

operationalised, it is timely to examine the impact that the IDCCRA has had on the lives of the individuals who have become subject to it.

Whilst many discourses could have been identified, three discourses were dominant in the data that provided a number of subjectivities for care recipients and providers. The first of these related to the intellectually disabled person.

The Intellectual Disability Discourse

The intellectual disability discourse was dominant over time, from the drafting of the Act to the completion of this research. Even in the context of the New Zealand Disability Strategy and the UNCRPD, the prominence of this discourse was still evident in legitimising the way that care recipients were viewed and treated.

The legal and clinical processes utilised to assess an intellectually disabled offender for suitability to become care recipients and the systems of care provided whilst under compulsory care reflected the dominance of the intellectual disability discourse. As discussed in Chapter Five the intellectual disability discourse draws on a medical model in providing an understanding of intellectual disability. Care recipients were constructed as individuals with a permanent intellectual impairment, inherently unwell and in need of treatment. As a result of this construction they were viewed as always vulnerable, potentially dangerous and in need of state control.

The assessment of intellectual disability is a process that is socially constructed and based on our understanding of language in relation to notions such as impairment, cognitive ability, and deficit. This is particularly highlighted in the legal system, where particular findings are challenged on the basis of legal terminology and understanding. Ngatai stated the following in his research on the IDCCRA:

In light of multiple decisions made in the Courts where the diagnosis of intellectual disability has been a focal issue, coupled with the fact that the criminal Courts cannot revisit sentencing after a convicted offender has been ordered under the IDCCRA, a thorough initial assessment of intellectual disability was viewed as being absolutely critical. (Ngatai, 2013, p. 56).

This point regarding the assessment of intellectual disability is significant. It reflects the constructed nature of intellectual disability as indicated by case law where diagnoses have been overturned in court. It also identified the consequence of such a construction being overturned, as the offender would potentially be released due to the court's inability to revisit sentencing.

The impact of an intellectual disability discourse on service providers was that they were constructed as parental and as such had power and decision-making authority over care recipients. This implied a duty of care for service providers over care recipients that sometimes reached beyond the period of compulsory care, due to the care recipient being constructed as vulnerable. It also brought a particular kind of focus to the care and rehabilitation on meeting perceived disability support needs such as attending to self-care and activities of daily living.

Of concern, the intellectual disability discourse is still evident in the way that people with intellectual disabilities who engage in behaviour of risk are constructed. In 2012 the report by the Independent Monitoring Mechanism of the Convention on the Rights of Persons with Disabilities made the following recommendation: "The Ministry of Justice and the Ministry of Health review arrangements for the provision of appropriate detention facilities, where needed, for people with an intellectual/learning disability who have not committed a criminal offence" (Human Rights Commission et al., 2012, p. 89). This statement serves to

construct intellectually disabled people as in need of social control through withdrawal from the community and represents a move away from community integration.

The provision of compulsory care to individuals who had not committed imprisonable offences was one of the primary issues discussed during the parliamentary debates. Subsequent to a number of submissions regarding the potential breach of rights, coverage for the non-offender group was removed. The fact that ‘detention’ was suggested by the monitoring group whose role was to report on potential breaches of rights indicates the dominance of the intellectual disability discourse.

Following some feedback from the Ministry of Health regarding the potential breach of rights implicit in this recommendation, it was changed in the following report to, “There is an apparent lack of appropriate facilities in some areas of the country for people with an intellectual disability. These are people requiring residential or intensive support and care who have not committed a criminal offence (Human Rights Commission, Office of the Ombudsman, & The New Zealand Convention Coalition, 2014, p. 65).”

In the new report ‘detention’ becomes ‘residential and intensive support’. What this demonstrates is that even in the context of a specific focus on the rights of disabled people, other discourses, such as an intellectual disability discourse as described in the current study, can come into play.

The intellectual disability discourse has brought a number of individuals into view as ‘disabled people’ with their placement under the IDCCRA. This is reflected both in the literature (Barron et al., 2004; Duncan, 2013; Prebble et al., 2013) and the findings of the current study. These were young, complex offenders who have not previously received disability support services. Prior to the IDCCRA it is likely that these individuals were dealt

with by mainstream criminal justice processes. This group was identified by Dawson in his 1997 discussion paper as being more appropriate for mainstream criminal justice processes with involvement from both probation and disability service providers (p. 10). Dawson identified social and environmental context as being relevant to the offending behaviour of this young group. Criminal behaviour was constructed as symptomatic of the social and environmental context they had come from, rather than directly resulting from an intellectual disability.

Considering the context for care recipients has the effect of constructing them as having potential to improve within the provision of a different environmental context. The prominence of an intellectual disability discourse, with its permanent impairment and vulnerable subject positions, could result in the care and rehabilitation provided by the IDCCRA falling short for this young group. The dominance of the intellectual disability discourse had a limiting effect on rehabilitation, which became shaped in the interests of meeting care recipients' disability support needs only.

In 1996 the Ministry of Health sought to gather information regarding a potential cohort for the Act by conducting a survey within disability services to “discover where these *dangerous people were* located, the nature of the behaviours that were perceived as being ‘*seriously dangerous*’...the nature of the services that currently support them, and an indication of desirable support services for them” (Webb & Capie, 1996, p. 3) (Italics in original).

By surveying disability providers, the Ministry of Health indicated that they saw the potential cohort as already engaged with disability support services. Also signalled was the later move to contract disability support providers to provide care under the IDCCRA framework. According to Dawson (1997), it was unlikely that the young offender group

identified above was captured in the survey due to their limited engagement with disability services.

The current study has shown the implications of the decision by the government to contract disability service providers and resulting dominance of the intellectual disability discourse. In particular, care and rehabilitation has developed with a primary focus on meeting disability support needs. In Chapter Five, Harry, a care recipient, saw himself as being inappropriate for placement in disability services because he did not see himself as ‘permanently impaired’ or indeed vulnerable. He clearly stated that he would have preferred an ordinary sentence of imprisonment. Harry identified a level of segregation and social isolation from his peers in terms of his placement within disability services. For Harry, being placed under the Act meant that he felt alone and out of place.

For care recipients who took part in this study, being constructed as permanently impaired and childlike meant that the opportunities for improvement and ultimately reintegration into the community became limited. The implications were that individuals may remain under the IDCCRA for extended periods of time if they were unable to demonstrate the necessary improvements. Improvements were about demonstrating the conduct of a good citizen. Our understanding of ‘a good citizen’ is in turn a social construction.

The Criminal Discourse

The subject positions offered to care recipients and service providers in this study by a criminal discourse had particular effects. A criminal discourse offered ‘criminal person’ and ‘person doing time’ subject positions for care recipients who were perceived as risky and in need of control. The issue of risk was very real for care recipients who had come

under the framework following engagement in criminal offending. The consequence of over-focusing on risk created the potential for care recipients to remain under the framework for extended period of time. This was a potential risk of the IDCCRA that was signalled by Brookbanks (1995) prior to the drafting of the Act.

In the absence of effective care and rehabilitation, the IDCCRA may provide the opportunity for prolonged detainment due to the ongoing perception of risk rather than a sentence appropriate to the original crime (Brookbanks, 2003). The current study proposes that with outcomes generated through clear rehabilitative goals embedded in a broader philosophical imperative of rights, the opportunity for prolonged detainment will be minimised.

The availability of the IDCCRA has brought another group into view as ‘criminal’ through the deployment of a criminal discourse. The behaviour of some individuals, particularly those within residential services, was now being criminalised through processes of charging and placement under compulsory care. Where behaviour may previously have been constructed as ‘challenging’, it was now being constructed as criminal.

There were a number of effects of this development. In some cases, as identified by Holly in Chapter Six, service providers were calling the police in response to incidents as an attempt to ensure that charges were laid. This was viewed as a mechanism to gain increased funding. This was also identified in Prebble et al.’s (2013) research where participants believed that in some cases the Act was being used as a “back stop for community services that were struggling to manage their client’s behaviour” (p. 9). Dawson (1997) also identified issues relating to resourcing when he stated, “Even where appropriate disposition options are now available for people with intellectual disabilities - as under the criminal

sentences of community programme or supervision - these are not often used, due to the absence of services” (p. 8).

Holly also made comment about the Act being used for low-level offending, which she viewed as inappropriate. As an alternative to a prison sentence, compulsory care should only occur following engagement in serious offending. This served to construct the identified individual as criminal where they were engaging in very low-level offending. Holly also spoke of situations where individuals had been charged as an attempt to meet what were considered broader social needs, such as drug and alcohol issues or homelessness.

Due to a level of institutionalisation or cognitive impairment, the IDCCRA had limited benefit for some individuals who had little ability to engage in care and rehabilitation. This meant that the IDCCRA was unlikely to create a change in behaviour for these individuals. This group was identified by Dawson (1997) in 1997, who noted that their potential for rehabilitation was limited and disposition under the IDCCRA was not recommended. With placement under the Act, these particular care recipients were now constructed differently and offered a criminal subjectivity. In Foucauldian terms, care recipients had become categorised in terms of their behaviour in comparison to others and also subject to enactments of disciplinary power. They were also subject to the negotiation of multiple identities, both criminal and intellectual disability.

The criminal discourse led to an overemphasis on containment, risk management and restrictive practices for use by service providers, whose primary focus became one of control and the limitation of freedom. Mary, a professional, was concerned about the focus on containment that she observed and expressed a desire for care recipients to receive more than containment and control whilst under compulsory care. She considered that this placed care recipients in a less desirable position than they would have had in receiving a prison

sentence which had a finite term. As identified by Prebble et al. (2013), professionals struggled with a tension between managing containment and facilitating a move towards freedom for care recipients.

The Capable Person Discourse

In terms of discrimination, the literature clearly reflects the marginal position that people with intellectual disabilities experience in our society (Barnes, 2003; Goodley, 2011). New Zealand academics such as Hilary Stace (2007) recognise the progress that New Zealand has made for disabled people, whilst acknowledging that there is a long way to go for disabled people to achieve equal status with others.

Care recipients as disabled people have experienced marginalisation and as care recipients, a limitation to their freedoms. A capable person discourse, drawing on a social model, socially constructs care recipients as having specific rights that accord them equality with other community members. In essence, they have the capability to be contributing community members and therefore the right to be so. A number of processes under the IDCCRA relate to the promotion and maintenance of rights.

According to Foucault (1977), the more abnormal and excluded a group is, the more individualised they become. The impact of individualisation has been explored in Chapters Five and Six. In order to free the excluded group and enable them to have a voice, Foucault articulated that either they need to be rendered anonymous or the systems that separate them from the rest of society need to be exposed (Foucault, 1977a). By laying bare the discursive processes enacted by the criminal and intellectual disability discourses, the current research has aimed to provide a level of critique. The intention is to provide a space for a counter discourse and its effects to be made visible, as described by Foucault:

It is through the re-emergence of these low ranking knowledges, these unqualified, even directly disqualified knowledges (such as that of the psychiatric patient, of the ill person, of the nurse, of the doctor parallel and marginal as they are to the knowledge of medicine that of the delinquent etc.)... it is through the re-appearance of these disqualified knowledges, that criticism performs its work. (Foucault, 1980, p. 82).

As identified in Chapter Seven, a capable person discourse counters the intellectual disability discourse and provides an alternative understanding of intellectual disability. Care recipients were constructed by a capable person discourse as having the potential to improve and reduce their offending behaviours. Service providers were constructed as educators who had a role in supporting the care recipient to meet their potential. Care recipients were considered capable of living an ordinary life just like any other person, as a contributing community member. Relationships with service providers were based on equality, with service providers constructed as facilitators of the care and rehabilitative process.

A capable person discourse brought the care recipients into view as capable, rather than merely constructing care recipients as permanently impaired or criminal. From a Foucauldian perspective, power produces subjectivities and knowledge about an individual. The capable person discourse opened new possibilities for understanding care recipients. They were then considered within the social, familial and environmental context that they came from. Consideration of context had particular effects.

One was that if they were understood within a broader context, the potential for change was created. Drawing on a social model, disability was constructed as arising from lack of opportunity as the environment has not provided care recipients with equal opportunities. With the right environment and discursive processes through the provision of

care and rehabilitation, the opportunity for change and ultimately community integration is offered. This is certainly true of the group of emerging care recipients whose context of environmental deprivation, drugs and alcohol and pro-criminal influences has had a significant impact on both their developmental progress and their behaviour (Duncan, 2013; Prebble et al., 2013). In my own professional experience, a change to a more structured and therapeutic environment has in itself led to significant changes for some young care recipients.

As discussed by Darcy in Chapter Seven, who spoke of ‘holding on’ for maturation to occur, the safety and security provided within a residential service with the presence of supportive staff can facilitate an increase in intellectual functioning and behaviour. Again noted by Darcy, by addressing the previous deprivation and by abstaining from drugs and alcohol some care recipients have demonstrated significant growth. A capable person discourse creates the potential for change, with the care recipient being brought into services for the duration of their compulsory care order. Also, arguably, care recipients who had not previously been in disability services had not suffered from discrimination on the basis of disability (Goodley, 2011).

Service providers were offered an educator subject position by a capable person discourse. In a Foucauldian sense they were agents of governmentality, tasked with the role of guiding the conduct and training of care recipients in order to create the necessary change for community integration (Foucault, 1980). Necessary changes involved a reduction in offending behaviour and an increase in learning and development. Service providers were constructed as having a strategic view that focused on what needed to happen for the individual to be released. As identified by Holly in Chapter Seven, they were considered responsible for ensuring a decrease in dependency for care recipients through the provision

of care and rehabilitation. They were constructed as equal to care recipients and had a role in ensuring care recipients' rights were protected.

Rights Protection

The effect of the rights of care recipients being brought into view was that the care recipients and the IDCCRA were placed within the broader context and focus on rights for disabled people. The context of the social model, which has driven the New Zealand Disability Strategy (Ministry of Health, 2001a), the Disability Action Plan (Office for Disability Issues, 2014) and the UNCRPD, had significant relevance for care recipients. The disability sector has faced significant change in the context of drives towards greater choice and control (Stace, 2007). Although subject to restrictions under the IDCCRA, care recipients face the same future as other disabled people.

It is essential that care recipients do not become further marginalised by the disability sector in terms of them being socially constructed as criminals. As stated by Holmes, speaking of psychiatric nurses working in a forensic hospital, “forensic psychiatric nurses need to be cautious that their approach to patients does not reinforce the stigma and discrimination of the wider community” (2005, p. 7). In the same way, people supporting care recipients must be both cognisant of and employ strategies that undermine discriminatory practices.

It is also essential that there is a strategic view and end goal in sight regarding community integration. This will ensure that care recipients will achieve the improvements necessary to be released from the IDCCRA. For care recipients, this means no longer being under compulsory care, living in the most independent living situation they can and accessing all the vocational, social, cultural, educational, spiritual and sexual activities that

most community members take for granted. These were the same goals that any person may have, including those with disabilities. In attempting to meet the goal of community integration, service providers and care recipients were required to negotiate multiple discourses.

Negotiating Multiple Discourses

A goal of discourse analysis is to identify ‘cultural hegemony’, or the dominance of one group over others, and to explore how this dynamic is created and reproduced (Cheek, 2000; Lupton, 1992). Dominant ideologies were both reflected by and perpetuated through language. Analysing the power relations within dominant discourses and identifying less dominant discourses allowed the opportunity for challenge and ultimately subversion. This was done by revealing discourse power effects and strategies (Foucault, 1977a).

As indicated in the research by Prebble (2013), care managers under the IDCCRA experienced a “tension between imperatives of risk management, rehabilitation and human rights” (p. 1). They also reported experiencing a level of role ambiguity in terms of their legal responsibilities around managing limits, such as leave approvals and behaviour management versus rehabilitation, which they viewed as facilitating autonomy and independence. The care managers in the current study reflected a similar view. They also cited a similar tension in terms of the conflicting roles they held. It is evident that they were subject to multiple discourses when negotiating their roles.

This was demonstrated by Sara in Chapter Six, who deployed a criminal discourse in relation to care recipients with a focus on risk management in terms of the information she was seeking about the individual. She also deployed a capable person discourse in that she

recognised that the person had potential, but this was communicated as a matter to consider at a later stage. Contradictory subject positions were demonstrated, with one subject position considering potential and the other considering risk and need for control. Here the criminal discourse constrains the capable person discourse, and one discourse is given priority over another.

In Foucauldian terms, it may be that as an individual becomes more 'normalised', other discourses become more visible. Once the person was better 'known', with risks clearly identified, there was an opportunity for a capable person discourse to be deployed in gaining understanding about the person. This demonstrates a negotiation of multiple discourses.

Service providers were also subject to the identities offered by criminal and intellectual disability discourses, which created a complex negotiation on their part in terms of the provision of care and rehabilitation. Both the intellectual disability and criminal discourses offered a subjectivity of control to service providers, who had decision-making authority over care recipients. The intellectual disability and criminal discourses offered complementary subject positions. This had the effect of compounding discipline and surveillance in the provision of care and rehabilitation. It also had the effect of limiting the presence of the alternative subject position of educator with a relationship of equality with care recipients as deployed by a capable person discourse.

Both the criminal and intellectual disability discourses created the potential for continued compulsory care through an over-focusing on impairment, risk management and need for containment and control. Arguably, care recipients were subjected to a process of double discrimination, as the effects of both subjectivities were marginalising. This has very real impact because they pose limited opportunities for employment and community

integration. This was identified by both Whitney and Walter in Chapter Six, who spoke of the difficulty in gaining employment after becoming a care recipient and following release from compulsory care.

Prebble et al.'s (2013) study also identified a level of "philosophical incompatibility" (p. 7) between legal requirements of the Act, particularly in relation to secure care such as alarms, locks and fences and disability organisations' "philosophies of choice and freedom" (Prebble et al., 2013, p. 7). Such philosophical imperatives were deployed by a capable person discourse. With the deployment of a capable person discourse, care recipients were constructed differently, with different power relationships and strategies of engagement for service providers. Constructions such as 'capable' and 'having an ordinary life' bring such philosophical imperatives into view. A capable person discourse creates the possibility of community integration.

Implications of Dual Role for Research

I have held multiple roles over the last decade under the IDCCRA framework and since I embarked on my DHSc in 2007. First I was a care manager in 2003, followed by care coordinator from 2004 to 2008. Then I was a regional manager, supervising care coordinators. In 2012 I moved to a role in the Ministry of Health as a senior advisor overseeing the implementation of the IDCCRA. My current professional role is now the Director of IDCCR with statutory responsibility for the administration of the IDCCRA designated by the Director General of Health. These roles have had implications for my engagement in this research. Likewise, my study has had implications for my professional role.

My research has been of significant benefit to my professional role. It has allowed me the benefit of understanding the IDCCRA within the context of literature and the broader historical, sociological and political picture over the last twenty years. It has also allowed me a level of reflection regarding how the framework operates.

Whilst I was in roles such as care coordinator, my reflections were largely in relation to operation at the service level. The Ministry of Health has statutory responsibility for the IDCCRA. Since the completion of my interviews, and with my role within the Ministry, my level of awareness of political and policy factors has broadened significantly. This has allowed me access to information that researchers may not ordinarily access. I believe it has allowed me to consider the application of the recommendations of this research not just with care recipients but on a political, policy and funding level.

In my current role I have influence over the direction of the IDCCRA. My intention is to use that influence to develop a framework that provides clear and effective rehabilitative outcomes for care recipients and de-marginalises the capable person discourse where possible. This has resulted in the inclusion of a rights-based philosophy to the model of care and rehabilitation that will be described later in this chapter.

Implications for Practice and Implementation

Having stated my intentions above, it is important to note that the findings of this research were limited to the group discussed by the participants in this study. Consideration of the literature and the findings of the current study provide some clear implications for the provision of care and rehabilitation to care recipients.

Managing Tensions

The question for the implementation of the IDCCRA was, “how does society protect people from harm to self and others whilst giving them full opportunity to live self-fulfilling lives?” (Taylor, 2005, p.94). The concept of least restrictive option has provided a philosophical underpinning to the legislation. Risk management is a necessary aspect of a compulsory care framework, but a criminal discourse constructs care recipients as inherently risky and dangerous. Again the question of managing risk becomes, “How can community services be offered in ways that maximise personal autonomy and choice without jeopardizing health and safety?” (Taylor, 2005, p. 94). Where freedoms are limited, liberty and rights become even more important. Care recipients in this study did not complain about their legal status in compulsory care. Rather, they complained about the choices that were taken away from them in terms of managing their daily lives. Criminal and intellectual disability discourses constructed service providers as in a position of power in which it was assumed that care recipients would not have control over any aspects of their lives.

A number of participants reported the view that in the absence of strategies to maximise independence through rehabilitation, care recipients were being subjected to punishment only. Fay, in Chapter Five, considered rehabilitation to be something more than what care recipients were being provided and in fact what they were entitled to. If an intellectual disability and criminal discourse continue to dominate, then a) needs may not be met, and b) rehabilitative strategies may focus on over-containment, resulting in continuing detainment and a lack of rehabilitative outcomes. Strategies are not only required for intellectually disabled offenders to be diverted from the criminal justice system; they are also required to ensure that care recipients are able to exit the IDCCRA.

According to Brookbanks (2013), “care in the context of the IDCCRA has come to mean containment in a care facility pending the termination of the care order” (2013, p. 223). However, I suggest that in the deployment of a capable person discourse as a counter discourse, the possibilities for provision of more than ‘care’ described in this way becomes possible. Another implication for practice is that care recipients are not all the same.

One Size Fits All

Whilst the care recipients participating in this study were of different ages and ethnicities, and one was female; age, ethnicity and gender did not emerge during the interviews as factors that shaped their talk of their experiences. It is important to note that many care recipients do not fit the stereotypical understanding of people with intellectual disability. Many do not fit the predicted profile envisaged by the number of reports provided in preparation for the passing of the IDCCRA. According to the literature and government statistics particular complexities are presented by youth, women and Māori.

Youth

The IDCCRA was intended primarily to provide compulsory care for adults. Whilst Dawson (1997) identified the young offender group, he did not recommend that the IDCCRA provide coverage for this group. Dawson saw them as more appropriately managed by normal criminal justice processes with some involvement of disability services to meet disability support needs (1997). Dawson also noted that due to a lack of alternative options, this group would likely become a point of pressure for the IDCCRA framework (1997). As noted by Duncan (2013), Prebble et al. (2013) and the findings of this study, youth are an emerging group for the IDCCRA. Demographics at the end of 2014 show that care recipients aged 18 years and under comprised 6% of the care recipient group. The

implications are that the framework will be required to adapt to the needs of this young offender group.

Women

At the end of December 2014, women comprised 14% of the care recipient group. As noted in the literature by Hayes (1997) and Duff & Sakdalan (2007), a small number of women under criminal justice frameworks can lead to their needs not being recognised, let alone met. This is due to programmes being aimed at the majority of offenders, who are men. The study by Lindsay, Steele, Smith, Quinn and Allan found that female offenders presented with multiple and complex issues compared with men (2006, p. 115). The complexity of female care recipients under the IDCCRA has also been noted (Daysh, 2008).

One issue that has emerged in the current research is that of sexual violence for women. The experience shared by Kelly in Chapter Five is consistent with the literature, in which experiences of abuse were highlighted by Hayes (2007b), Roguski (2013) and Mirfin-Vietch et al. (2014) as relatively common for intellectually disabled women. Whilst abuse is an issue broadly for disabled people, sexual violence is more common for female offenders in particular (Hayes, 2007b). Scholarship reflects that people in a position of dependence, such as those under the IDCCRA, are relatively more vulnerable to abuse (Mirfin-Veitch et al., 2014). In the context of considering broader rights issues for care recipients, it is essential that discrimination and sexual violence are considered in relation to female care recipients. If these issues are not considered in the context of providing care and rehabilitation, then the IDCCRA is not likely to meet the needs of this group.

Māori

Demographics reflect a level of overrepresentation for Māori, who comprised 38% of the care recipient population in December 2014 compared with 14% of the general population (Statistics New Zealand, 2013). The current study did not identify any specific discourses relating to care recipients as Māori. It is possible that the dominance of the intellectual disability and criminal discourses obscured potential discourses relating to the care recipients as Māori. Overrepresentation of Māori in both disability and criminal justice sectors likely provides a greater level of marginalisation for Māori care recipients. It is also likely that the experience of being Māori magnified the power effects of both the criminal discourse and the intellectual disability discourse for Māori care recipients, who were required to negotiate multiple discourses in how they understood themselves.

The needs of Māori must be considered in the context of the provision of care and rehabilitation (Duncan, 2013). As noted in Chapter Three, cultural assessment processes are provided under the IDCCRA as a mechanism to ensure that the needs of Māori are appropriately assessed and met. Although not discussed in the current study, it is unclear whether the provision of cultural assessment provides any impact on the provision of care and rehabilitation under the IDCCRA. What it does highlight, however, is the need to consider this group in the development of a model of care and rehabilitation under the IDCCRA.

Model of Care

Research such as O’Callaghan (2012), Ngatai (2013), Prebble et al. (2013) and Duncan (2013) all suggest that the model of care provided under the IDCCRA needs to be further developed. Again as noted by Duncan (2013), the Ministry of Health, in partnership

with the National Intellectual Disability Care Agency, is currently developing a new model of care and rehabilitation for care recipients. The model will integrate systems of risk assessment and strategies that will better meet the needs of care recipient as both offenders and intellectually disabled people (Duncan, 2013). Although not noted by Duncan, the model of care and rehabilitation will also include an overarching philosophical imperative of community integration and rights protection for care recipients. The provision of care and rehabilitation must include consideration of the UNCRPD, particularly in relation to Articles 12 (Equal recognition before the law) and 13 (Access to justice), which have particular relevance for care recipients.

It is essential that the framework provides service providers with the appropriate training and a model of care that fosters independence and reduced control. Disability providers and support staff need to become aware of the marginalisation of disabled people. As also identified by Ngatai (2013), the current study similarly found the need for workforce development. Participants reported that service providers were in need of further training in relation to a range of issues. In Chapter Five, Whitney noted the need for support staff to develop coping strategies for dealing with problematic behaviour. Also highlighted was the need to support care recipients in ways that upheld their rights, as described by care recipients Kelly and Harry. This research has identified that care recipients may be particularly vulnerable to power effects in terms of both the restrictions they were subject to and the impact of discourses such as intellectual disability and criminal that serve to disempower and silence them.

Limitations of Study

One limitation to discourse analysis is that it provides an analysis that is context specific. Therefore, it is difficult to generalise the results of this study. It is specific to the

participants, the time that the research was conducted and to the area it was conducted in — Auckland, New Zealand. The study has provided a limited sample with 17 participants. Care recipient participation was limited to a specific time period. This was six months prior to or within six months following release from the IDCCRA. The current study does not provide a longitudinal view; nor does it focus on empirical data. The findings were limited to the IDCCRA and did not contemplate the implications of other statutes. The IDCCRA is still developing, and any findings were only relevant to this time period. A limitation of the study was that it did not draw out discourses or discursive practices deployed in relation to care recipients' age, ethnicity and gender. These are worthy of future research. It also, as stated in Chapter Four did not focus on the nature of offending that the participants were charged with.

However, social constructionist discourse analysis makes no claim to universality (Cheek, 2000). Any findings are limited and partial to this study and its participants. It is likely that with a different context or line of questioning that the participants may have drawn on different discourses to represent their experiences. According to Cheek, the allowance of multiple perspectives is a strength of discourse analysis but may become a limitation where the approach to the research is poorly described or the theoretical framework is not adequately defined and clearly linked to the research (Cheek, 2000). The current study has sought to demonstrate a robust methodology with methods that are clearly linked to the research aims.

Recommendations of the Study

Recommendations for Research

Although not examined in the current research, future research on whether the IDCCRA as a diversionary system which provides a range of specialist supports and good community options has led to decreased offending for this group is essential. Future research also needs to contemplate issues raised by authors such as Brookbanks (1995, 2003, 2013), Prebble et al. (2013) and Diesfeld (2013) regarding the rights implications of extensions under the IDCCRA. Discussion of case law and the views of professionals under the framework are important. Consideration of these issues also needs to be grounded in evidenced-based discussion.

As already discussed, specific focus needs to be given to Māori in the context of future research. As also identified, the needs of female care recipients warrant more comprehensive consideration in research. Although small in number, anecdotal information suggests they will increase in number and their needs will become more complex over time.

Recommendations for Education

The need for specialist staff is well cited in the literature and in this study (Brandford, 2000; McLean & Hartnett, 2005). A number of participants talked about service providers needing to develop further skills in relation to the support and management of this very complex group. Service providers need to be well educated in how to deal with individuals who behave in a manner that puts themselves and others at risk. They need to understand how to do this whilst facilitating the greatest freedom and choice possible for care recipients. Service providers need to be linked in with existing educational programmes that address such issues.

In the same way, people supporting care recipients must be both cognisant of and employ strategies that undermine discriminatory practices. Service providers need to be educated in how to ensure rights protection. They need to understand broader issues related to discrimination. Programmes need to be developed by providers that ensure that service providers understand what integrating people into the community means and how to achieve it.

Recommendations for Policy and Practice

As indicated in this chapter, the framework around the legislation needs to ensure that it continues to develop care and rehabilitation in response to the needs of individual care recipients. I recommend the further development of a model of care and rehabilitation that will meet the needs of all care recipients and not just those who fit the traditionally understood intellectually disabled person or offender.

I believe that embedding the model of care for care recipients within the broader disability sector imperatives such as empowerment, choice and control is essential to ensure that their rights are fully understood. The Ministry of Health must work to ensure that care recipients do not become marginalised from the mainstream disability sector. Furthermore, slippage regarding the rights of individuals with an intellectual disability who engage in offending behaviour needs to be monitored. As evidenced in the *Making Disability Rights Real* (2012) independent monitoring report, slippage occurs very easily with this group, even from a group whose role is to monitor breaches of rights.

Another recommendation for policy and practice is for the Ministry of Health and service providers to conduct evaluation of the outcomes provided by care and rehabilitation. This will allow a measure of how well the goals of the legislation have been achieved. This

will be particularly important in light of the development of a new model of care and rehabilitation. It will also allow an examination of whether care and rehabilitation is developing in line with the features of the care recipient population. A further recommendation relates to ensuring that entry and exit thresholds are appropriate. Again, strategies are not only required for intellectually disabled offenders to be diverted from the criminal justice system; they are also required to ensure that care recipients are able to exit the IDCCRA.

A number of participants raised the issue of resources in relation these thresholds. Holly spoke of providers involving the police in relation to challenging behaviour as a mechanism to exit an individual or gain further resources. Others mentioned lack of resources being available following release having an impact on the success of community integration. The study recommends that these issues are explored further in relation to resources available within mainstream services and in the community.

The final recommendation for policy and practice relates to ensuring that the voices of care recipients themselves are completely present in the development of the framework. The care recipients in this study were very clear about the support they expected from service providers. They were clear about what they did not expect nor should have to tolerate. They were also clear about the life they wanted following release. Listening to their views can only serve to improve outcomes.

Conclusions

The thesis explored the impact of discourses on the provision of care and rehabilitation under the IDCCRA. The aim was to explore dominant discourses deployed by service providers and care recipients to reveal their subject positions and power effects. The

aim was also to highlight less dominant discourse that provided alternative social constructions for care recipients; in particular, discourses that position care recipients as capable with the potential to be active and valued community members.

The identification of discourses revealed the potential impact of the legislation on the care recipients themselves in terms of their identity, their social status and their ability to live as valued community members. The study recommended the development of a model of care that has a focus on rights protection and community integration as well as reducing the risk of reoffending.

Without adequate resourcing there is a risk that effective rehabilitation outcomes will not be provided by the IDCCRA. Rehabilitation is only possible in the context of considering the broader picture of the rights of people with intellectual disabilities. Deploying a capable person discourse that constructs care recipients as having potential and provides rehabilitation to aid community integration will allow for a model of care that provides better outcomes for care recipients. Only then will care recipients be supported to achieve their potential as integrated, contributing community members.

The findings of the current study suggest that the way to facilitate change effectively and minimise potential harm for care recipients is to take a societal and systemic approach. With outcomes generated through clear rehabilitative goals embedded in a broader philosophical imperative of rights, the opportunity for prolonged detainment will be minimised. It is not about dealing with the offender; rather, it is about dealing with society in a way that will reduce the marginalisation of care recipients and ultimately improve their behaviour as they become contributing community members.

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APPENDICES

Appendix A – Research Proposal Timata Hou

Amanda Smith

Doctoral Candidate

AUT University

C/-Access Ability Ltd

PO Box 23725

Hunters Corner

Linda Windley

Regional Manager

Timata Hou Auckland

19th April 2010

Dear Linda,

In follow up to our conversation regarding my research I would like to request the completion of the attached documentation which gives organisational approval to my approach of Timata Hou staff and those individuals who you support who have been subject to the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003.

Please find below a summary of the proposed research. Do not hesitate to contact me should you require further information.

Experiences of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003

A summary of research proposed by Amanda Smith, Doctoral Candidate:

The Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 has now been in operation since 2004. Over that time a number of social, political and legal themes have emerged. Little research has been conducted to date that explores the implementation of the IDCC&R Act. The current study will examine the implementation of the Act through the experiences of the care recipients themselves and those who work with them.

Up to twenty individuals will be interviewed regarding their experiences of the ID(CC&R) Act. Interviews will be semi-structured and will focus on the following:

- Their views regarding the development of the act and accompanying supports
- Discussion regarding processes both within the Act and within the IDCC&R sector
- Identification of key stakeholders and relationships
- Discussions regarding the identity and social position of care recipients both as perceived by themselves and others.

It is anticipated that the findings will inform the ongoing development of the ID(CC&R) Act in terms of the potential impact of compulsory care under this legislation for intellectually disabled offenders in New Zealand.

Participants

All participants will have some involvement in the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 framework. All 'care recipients' will have needs assessment

and service coordination provided by the Regional Intellectual Disability Care Agency and will reside in a Regional Intellectual Disability Supported Accommodation Service provider such as Te Roopu Taurima O Manukau and Timata Hou.

Potential participants can be divided into four groups.

1. Service providers:

Up to five residential support workers will be interviewed. These will be individuals who support care recipients on a daily basis in the residential services within which they are placed. It is likely that a number of service providers who participate will be Māori and consideration of tikanga will occur in relation to interviewing these individuals.

2. Professionals:

A total of five people from the following fields will be interviewed - (psychology, nursing, occupational therapy, psychiatry, law). These will be professionals who currently provide assessment, treatment, advocacy and/or support to care recipients.

3. Care recipients:

Up to five individuals will be interviewed who have either just completed the term of their compulsory care order within the last six months or are about to complete within next six months.

4. Support people:

Up to five individuals who provide support and/or advocacy for care recipients will be interviewed. This could include welfare guardians, family members and disability advocates.

Research Process

1. Recruitment

Potential participants who are support people and professionals will be recruited through invitation sent to the organisations that they work for or directly to them if they are self-employed. Those individuals who are care recipients will be recruited by invitation through their care managers. Individuals will be able to decide themselves whether or not they would like to take part.

2. Data Collection

Data will be collected in the following way. Semi-structured interviews will be conducted. Interviews will be tape recorded with permission and transcribed for analysis. Once the interviews are completed and transcribed participants will be given a copy to review. Participants will be given a pseudonym to ensure confidentiality.

Interviews will take place at a time and place that suits the participant and the researcher. These will likely include Te Roopu Taurima O Manukau Trust, Timata Hou Ltd and Access Ability Ltd.

3. Data storage

All data will be kept in a locked cabinet both during and following the completion of the research. Raw data will either be returned to participants or destroyed. Data from the study will be kept by the principal researcher for 10 years in a secure location. Participants will have the opportunity to meet with the researcher to discuss results. They will have the opportunity to have any raw data returned to them. Interviews will be digitally recorded and participants will be offered a CD or printed copy of their interview.

All participants will be sent an information sheet prior to participation. A representative from People First has been consulted in the development of the information sheet to ensure that it is appropriately written for individuals with an intellectual disability. Information sheets may also be provided to non-participants such as family members and welfare guardians. Further information may be provided in person or by phone.

Potential participants will also be sent a consent form to be completed. It is vital that the individuals are fully informed in order to give consent. Where welfare guardians are in place for individuals they will be fully consulted in terms of the project and in terms of any issues related to informed consent.

Research Findings and Dissemination

All participants will have the opportunity to review and discuss the research results including being provided with a copy of the report. The researcher will meet with care recipients individually should they wish to do so. Key stakeholders will also be invited to meetings to discuss results for example Te Roopu Taurima O Manukau, Timata Hou, People First, Access Ability. Research findings will be presented at the NZASID conference and the AASID in Brisbane in September. It is intended that research findings will be published in disability related journals.

Benefits of participation

Participation will provide the opportunity to discuss any relevant issues they might have regarding the ID(CC&R) framework and their experiences of it. Taking part will also provide the opportunity to contribute to increased learning regarding the framework and the field of intellectual disabilities and the criminal justice system.

Risks of participation

Psychological risks include potential distress for care recipients due to talking about their experiences of going through a legal process and being under a compulsory care order. As part of the interview process the researcher will ensure that appropriate support people are available in order that participants can debrief any issues that they wish to.

As already mentioned please do not hesitate to contact me should you require any further information.

Yours sincerely

Amanda Smith

Appendix B – Research Proposal Te Roopu Taurima

Amanda Smith

Doctoral Candidate

AUT University

C/-Access Ability Ltd

PO Box 23725

Hunters Corner

Tena Koutou,

I am writing to seek cultural support and guidance in reference to a research project that will be completed as part of a Doctorate in Health Science at AUT University. Ethics approval has been sought from the New Zealand Health and Disability Ethics Committee, Ministry of Health.

As this research will likely involve Te Roopu Taurima O Manukau Mokopuna, Kaiawhina and Kaitataki it is imperative that I engage in this research process in a partnership process with all aspects of Tikanga considered to ensure that cultural safety and integrity is upheld for all individuals involved.

I have requested the support of Te Hurihanga Rihari to advise me throughout my research process in regard to specific research processes and consideration of any findings and their potential significance for Māori who become subject to the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003.

Please find below a summary of the research project. Please feel free to contact me regarding any further clarity that I can provide in terms of your decision.

Yours sincerely,

Amanda Smith

Experiences of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003

A summary of research proposed by Amanda Smith, Doctoral Candidate:

The Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 has now been in operation since 2004. Over that time a number of social, political and legal themes have emerged. Little research has been conducted to date that explores the implementation of the IDCC&R Act. The current study will examine the implementation of the Act through the experiences of the care recipients themselves and those who work with them.

Up to twenty individuals will be interviewed regarding their experiences of the ID(CC&R) Act. Interviews will be semi-structured and will focus on the following:

- Their views regarding the development of the act and accompanying supports
- Discussion regarding processes both within the Act and within the IDCC&R sector
- Identification of key stakeholders and relationships
- Discussions regarding the identity and social position of care recipients both as perceived by themselves and others.

Using a social constructionist methodology issues will be critically analysed for criteria such as subject positioning and power relationships and any potential impact for the identity of care recipients will be explored. This will include consideration of any issues relating to cultural identity whilst under the legislation.

It is anticipated that the findings will inform the ongoing development of the ID(CC&R) Act in terms of the potential impact of compulsory care under this legislation for intellectually disabled offenders in New Zealand.

Participants

All participants will have some involvement in the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 framework. All 'care recipients' will have needs assessment and service coordination provided by the Regional Intellectual Disability Care Agency and will reside in a Regional Intellectual Disability Supported Accommodation Service provider such as Te Roopu Taurima O Manukau and Timata Hou.

Potential participants can be divided into four groups.

1. Service providers:

Up to five residential support workers will be interviewed. These will be individuals who support care recipients on a daily basis in the residential services within which they are placed. It is likely that a number of service providers who participate will be Māori and consideration of tikanga will occur in relation to interviewing these individuals.

2. Professionals:

A total of five people from the following fields will be interviewed - (psychology, nursing, occupational therapy, psychiatry, law). These will be professionals who currently provide assessment, treatment, advocacy and/or support to care recipients.

3. Care recipients:

Up to five individuals will be interviewed who have either just completed the term of their compulsory care order within the last six months or are about to complete within next six months. It is anticipated that two or three care recipients will be Māori and it will be really important to consider tikanga in relation to their engagement in the research process.

4. Support people:

Up to five individuals who provide support and/or advocacy for care recipients will be interviewed. This could include welfare guardians, family members and disability advocates.

Research Process

1. Recruitment

Potential participants who are support people and professionals will be recruited through invitation sent to the organisations that they work for or directly to them if they are self-employed. Those individuals who are care recipients will be recruited by invitation through their care managers. Individuals will be able to decide themselves whether or not they would like to take part.

2. Data Collection

Data will be collected in the following way. Semi-structured interviews will be conducted. Interviews will be tape recorded with permission and transcribed for analysis. Once the interviews are completed and transcribed participants will be given a copy to review. Participants will be given a pseudonym to ensure confidentiality.

Interviews will take place at a time and place that suits the participant and the researcher. These will likely include Te Roopu Taurima O Manukau Trust, Timata Hou Ltd and Access Ability Ltd. Where the interviewee is Māori the location will need to be considered in terms of maintaining the individual's wairua, tinana and hinengaro. This means that the location will be decided in consultation with them, will ensure privacy and confidentiality and will attend to any physical needs. It is likely that karakia timatanga and karakia whakamutunga

will be utilised to open and close meetings and the provision of food towards the end to ensure whakanoa. Consideration of family involvement will also be made.

3. Data storage

All data will be kept in a locked cabinet both during and following the completion of the research. Raw data will either be returned to participants or destroyed. Data from the study will be kept by the principal researcher for 10 years in a secure location. Participants will have the opportunity to meet with the researcher to discuss results. They will have the opportunity to have any raw data returned to them. Interviews will be digitally recorded and participants will be offered a CD or printed copy of their interview.

All participants will be sent an information sheet prior to participation. A representative from People First has been consulted in the development of the information sheet to ensure that it is appropriately written for individuals with an intellectual disability. Cultural advice will also be sought in relation to the information sheet before a finalised copy is produced. Information sheets may also be provided to non-participants such as family members and welfare guardians. Further information may be provided in person or by phone.

Potential participants will also be sent a consent form to be completed. It is vital that the individuals are fully informed in order to give consent. Where welfare guardians are in place for individuals they will be fully consulted in terms of the project and in terms of any issues related to informed consent.

Research Findings and Dissemination

All participants will have the opportunity to review and discuss the research results including being provided with a copy of the report. The researcher will meet with care recipients individually should they wish to do so. Key stakeholders will also be invited to meetings to discuss results for example Te Roopu Taurima O Manukau, Timata Hou, People First, Access Ability. Research findings will be presented at the NZASID conference and the AASID in

Brisbane in September. It is intended that research findings will be published in disability related journals.

Benefits of participation

Participation will provide the opportunity to discuss any relevant issues they might have regarding the ID(CC&R) framework and their experiences of it. Taking part will also provide the opportunity to contribute to increased learning regarding the framework and the field of intellectual disabilities and the criminal justice system.

Risks of participation

Psychological risks include potential distress for care recipients due to talking about their experiences of going through a legal process and being under a compulsory care order. As part of the interview process the researcher will ensure that appropriate support people are available in order that participants can debrief any issues that they wish to. This will be very important to keep the mana of the individual interviewee intact.

Relevance for Māori

Based on current numbers, particularly in the Auckland/Northland region Māori represent about thirty percent of care recipients. It is likely that two to three participants who are care recipients will be Māori. It is unknown how many support people/professional participants will be Māori.

Due to the overrepresentation of Māori both within the criminal justice system and the ID(CC&R) framework Māori participants will be included to ensure a Māori perspective is fully canvassed. It is vital that the particular issues that Māori face as they negotiate this framework are identified. It is likely that the discrimination that Māori face within the criminal justice system is exacerbated by the added factor of disability. This creates an inequality that must be noted. It is hoped that this research by identifying particular discourses that create power inequities that strategies for subverting such discourses may be

possible. A central goal will be the improvement of processes within the ID(CC&R) framework that better suit the needs of Māori care recipients.

Consultation has occurred with Representatives from Te Roopu Taurima O Manukau to discuss both the impact that this research may have for Māori and the processes by which Māori participants are engaged in the research. Consultation will also happen regarding participant information forms, consent forms and interview questions in terms of their appropriateness for Māori participants.

Guidance will be provided by the executive manager of Te Roopu Taurima O Manukau who will consult throughout the research process in a partnership process should support from Te Roopu Taurima be successful.

Meetings will be held regularly with the cultural advisor throughout the entire research process. This will be to get feedback regarding process for Māori and to identify any issues of concern in terms of the findings of the research.

Amanda Smith

Appendix C - Information Sheets**For care recipients**

Participant Information Sheet

1st May 2010**Experiences of the Intellectual Disability****(Compulsory Care and Rehabilitation) Act 2003.****An Invitation:**

Hi, my name is Amanda Smith. I am inviting you to take part in a study about what it is like to be placed under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003. I am doing this study as part of a Doctorate in Health Science.

What is this study about?

The Act has now been in place for five years. This study is about finding out what being placed under the Act has been like for you.



I hope that the results of the study will tell me something about the effects of the Act on the lives of people with an intellectual disability.

How did I choose you?

You were chosen because you have been placed under the Act. I got your name through your care manager who told me that you were about to or had already come off your compulsory care order.

What will I have to do if I choose to take part?

If you choose to take part in the study I will interview you. The interview will take about an hour. I will interview you in a place where you are comfortable.

The interviews will be tape-recorded but you can have the tape turned off whenever you want to. Your real name will not be used.



You don't have to talk about anything that you don't want to. Also, you can change your mind about taking part at any time.

I might write down some notes during the interview and after the interview ends.



What do I do if I want to take part?

If you would like to take part you can let your care manager or me know and sign a consent form. I have included a consent form for you to look at. I am happy to explain what the form says.

What might be hard about taking part?

It may be that it is hard to talk about why you came to be under the Act, and what it has been like while you have been under the Act. This might be upsetting for you.

What will make it easier?

We can take breaks whenever you like. I will also make sure that you have support people to talk to. This could be your key worker or your care manager or another person you would prefer.

What are the good things about taking part?

Taking part in this study will give you a chance to have a say and tell me what you think about the act. It is likely that you will have important information to share that will help other people who come under the Act.

What happens if I don't want to be part of the study?

Nothing. If you don't want to take part it is up to you. No one can tell you that you have to take part in research. It would be great if you could let me know by (insert date) if you would like to take part. You can ring me at the number below or you can get your care manager to phone me on your behalf.

How will my privacy be protected?

The study is completely confidential. This means that anything you tell me will be private and your real name will not be used in the study. The interviews will be written up and these documents will be kept locked away. Only me, my supervisors and the person who writes up the interviews will have access to your interview write up. Anything that has your name on it will be taken out.

You will also have the chance to read the interview write up and make any changes that you want to.

The only time I might tell anyone else what you have told me is where you or someone else is at risk of being harmed.

Will you tell me what you find?

I am happy to meet with you after the research and talk to you about what I have found out.

Thank you for thinking about taking part in this study



Who do I contact if I want to more about the study?

Amanda Smith, amanda.smith@accessability.org.nz, (09) 2625370, 0273329749.

What do I do if I have concerns about the study?

If you have any worries you can contact:

Dr Deborah Payne, debbie.payne@aut.ac.nz, (09) 9219999. ext. 7112

Associate Professor Kate Diesfeld, J.D, kate.diesfeld@aut.ac.nz, (09) 9219999, ext. 7799

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTECH, Madeline Banda, madeline.banda@aut.ac.nz , 921 9999 ext 8044.

If you have any queries or concerns regarding your rights as a participant in this study, you may wish to contact an independent health and disability advocate:

Free phone: 0800 555 050

Free fax: 0800 2 SUPPORT (0800 2787 7678)

Email: advocacy@hdc.org.nz

*This study has received ethical approval from the Northern X Regional Ethics Committee
25/05/10 reference number NTX/10/04/029*

For support people and professionals

Participant Information Sheet



1st May 2010

Experiences of the Intellectual Disability

(Compulsory Care and Rehabilitation) Act 2003.

An Invitation:

You are invited to participate in a research project looking at the experiences of care recipients who are placed under the Intellectual Disability (Compulsory Care and Rehabilitation Act) 2003. This research project is for the completion of a Doctorate in Health Science (DHSc).

The invitation is being extended to individuals who are involved in supporting care recipients either in a professional and/or support role.

Your participation in the study is voluntary. You can withdraw at any point prior to any interview you may have. Should you choose either not to participate or at any stage to withdraw from the study, this will not adversely affect your work within the ID(CC&R) sector.

What is the purpose of this research?

To date little research has been carried out to explore the experiences of individuals who become subject to the ID(CC&R) Act. The study will examine the implementation of the Act through the experiences of the care recipients themselves and those who work with them with a focus on the time six months prior to and following release.

It is anticipated that the findings will inform the ongoing development of the ID(CC&R) infrastructure.

How was I chosen for this invitation?

You were chosen because you either work with or support an individual that has become subject to the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003.

If you are interested in taking part in the study or obtaining further information about the study you may contact:

Amanda Smith, amanda.smith@accessability.org.nz, (09) 2625370, 0273329749.

If you have not been able to contact me in approximately two weeks after receiving this information, I will telephone you to find out whether or not you'd like to take part in this study.

What will happen in this research?

If you choose to take part in our study this will involve a face to face interview with the researcher at a time and place that is convenient for you.

The interview will take around sixty minutes. We will ask you to talk about your experiences of working with ‘care recipients’ under the ID(CC&R) Act 2003. In particular you might be asked about your views regarding the legislation, who you think the key stakeholders are, features of different environments utilised under the legislation and your perception of what life is like for care recipients following release.

With your permission the interview will be tape-recorded. The interviews will be transcribed by a typist who has signed a Confidentiality Form. You will be given a copy of the transcript to read and verify.

What are the discomforts and risks?

It may be that the interview will bring up events that are upsetting to you. You may request the interview to be either ended at this time, or stopped and then resumed at a later time. If you request we will give you the contact details of the AUT Health and Counselling Service.

Likewise, you may become tired during the interview. If this happens, you can ask to stop and either have a break or to continue it at a later date.

What are the benefits?

We do not anticipate that there may be direct benefits for you if you choose to participate. It is hoped that by disseminating the findings of this study that they may benefit future care recipients of this legislation.

How will my privacy be protected?

You will be asked to give another name that you will be known by during the interview, on the transcripts and in any publications or conference presentations that we produce from the study's findings.

Only the researcher, the researcher's supervisors and the transcriber will have access to your interview tapes and transcripts. Once interviews have been transcribed you will have an opportunity to review your transcript and make revisions. All copies of these will be kept in a locked filing cabinet for ten years. After this time they will be destroyed. Any material that may identify you will be deleted from the transcript.

There are exceptions to confidentiality where information provided indicates serious risk of harm to self or others.

What are the costs of participating in this research?

We do not anticipate any costs other than your time. At the most this will be one – one and a half hours.

What opportunity do I have to consider this invitation?

You will have two weeks to consider this invitation and to discuss the project with Family/whanau or a friend prior to signing the consent form. Approximately two weeks after you have been sent this information I will telephone you to ask if you wish to take part or not. You may contact me before this time if you would prefer.

'If you have any queries or concerns regarding your rights as a participant in this study, you may wish to contact an independent health and disability advocate:

Free phone: 0800 555 050

Free fax: 0800 2 SUPPORT (0800 2787 7678)

Email: advocacy@hdc.org.nz

If you belong to a professional body and have any queries or concerns regarding your rights as a participant in this study you may wish to contact your professional organisation.

How do I agree to participate in this research?

You may contact me on:

Amanda Smith, amanda.smith@accessability.org.nz, (09) 2625370, 0273329749.

Before the interview begins you will be asked to sign a Consent Form.

Will I receive feedback on the results of this research?

All participants will receive a summary of the research findings. If you request, you will be given a copy of the report.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisors:

Dr Deborah Payne, debbie.payne@aut.ac.nz, (09) 9219999, ext. 7112

Professor Kate Diesfeld, J.D, kate.diesfeld@aut.ac.nz, (09) 9219999, ext. 7799

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEK, Madeline Banda, madeline.banda@aut.ac.nz , 921 9999 ext 8044.

Compensation

In the unlikely event of a physical injury as a result of your participation in this study, you may be covered by ACC under the Injury Prevention, Rehabilitation, and Compensation Act 2001. ACC cover is not automatic, and your case will need to be assessed by ACC according to the provisions of the Injury Prevention, Rehabilitation, and Compensation Act 2001. If your claim is accepted by ACC, you still might not get any compensation. This depends on a number of factors, such as whether you are an earner or non-earner. ACC usually provides only partial reimbursement of costs and expenses, and there may be no lump sum compensation payable. There is no cover for mental injury unless it is a result of physical injury. If you have ACC cover, generally this will affect your right to sue the investigators.

If you have any questions about ACC, contact your nearest ACC office or the investigator.

You are also advised to check whether participation in this study would affect any indemnity cover you have or are considering, such as medical insurance, life insurance and superannuation.

Whom do I contact for further information about this research?

Researcher Contact Details:

Amanda Smith, amanda.smith@accessability.org.nz, (09) 2625370, 0273329749.

Project Supervisor Contact Details:


Dr Deborah Payne, debbie.payne@aut.ac.nz, (09) 9219999

Professor Kate Diesfeld, J.D, kate.diesfeld@aut.ac.nz, (09) 9219999

*This study has received ethical approval from the Northern X Regional Ethics Committee on 25/05/10
Reference number: NTX/10/04/029.*

Appendix D - Consent Forms

For care recipients

<h1>Consent Form</h1>	 <p>AUT UNIVERSITY <small>TE WĀNANGA ARONUI O TAMAKI MAKAU RAU</small></p>
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Project title: Experiences of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003.

Researcher: Amanda Smith

Project Supervisors: Dr Deborah Payne and Professor Kate Diesfeld, J.D.

- ☐ I know what the study is about and have read the information sheet dated 01/05/2010.
- ☐ I have asked any questions I needed to and have had them answered.
- ☐ I know that the interviews will be recorded and notes taken which will be written up
- ☐ I know that I can change my mind about taking part at any time and it won't be held against me
- ☐ I know that I can change my mind about particular things I have shared.
- ☐ I agree to take part in this research.

☐ For hearing impaired:

I would like a NZ sign language interpreter (please tick one)

Yes ☐ No ☐

☐ I want to talk to you after the research is finished about what you find (please tick one):

Yes ☐ No ☐

Participant's signature:

Participant's name:

Participant's Contact Details (if appropriate):

.....

.....

.....


.....

Date:

This study has received ethical approval from the Northern X Regional Ethics Committee on 25/05/10 Reference number: NTX/10/04/029

Note: The participant should retain a copy of this form

For support people and professionals

<h1>Consent Form</h1>	 <p>AUT UNIVERSITY TE WĀNANGA ARONUI O TAMAKI MAKAU RAU</p>
-----------------------	---

Project title:

Experiences of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003:

Project Supervisor: Dr Deborah Payne and Professor Kate Diesfeld, J.D.

Researcher: Amanda Smith

I have read and understood the information provided about this research project in the Information Sheet dated 1/05/2010.

- ☐ I have had an opportunity to ask questions and to have them answered.
- ☐ I have had ample time to discuss the project with Whanau/ family or friend prior to signing the consent form.
- ☐ I understand that the interviews will be audio-taped and transcribed.
- ☐ I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.

- ☐ If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.
- ☐ I am aware that the exception to confidentiality will be if the interviewer has significant concerns about the safety of myself and/or others.
- ☐ I agree to take part in this research.
- ☐ For hearing impaired:

I would like a NZ sign language interpreter (please tick one):

Yes ☐ No ☐

- ☐ I wish to receive a copy of the report from the research (please tick one):

Yes ☐ No ☐

- ☐ I wish to receive a copy of any publications from the research (please tick one):

Yes ☐ No ☐

Participant's signature:.....

Participant's name:.....

Participant's Contact Details (if appropriate):

.....

.....

.....

.....

Date:

*This study has received ethical approval from the Northern X Regional Ethics Committee on 25/05/10,
Reference number: NTX/10/04/029*

Appendix E – Interview questions

For care recipients

1. How long have you been living with the service?
2. Do you remember why you came here?
3. Can you tell me what happened when you went to court?
4. What happened when you came under an order?
5. What does being under an order mean?
6. Who do you live with?
7. Do you have staff support?
8. What do they do?
9. Who else comes to see you at your house?
10. Do you see any of your family?
11. What do you like about being here?
12. What do you not like about being here?
13. What do the words ‘compulsory care’ mean to you?
14. Do you know what a care and rehabilitation plan is?

15. If so, what's it for?
16. What is your favourite thing to do?
17. Tell me about a normal day for you
18. What would you like to do when your order finishes?
19. Who decides whether you stay under an order or not?
20. How do they decide?
21. What would you like to do when you leave?
22. Has your life been different since you came off your order?
23. What would you like your life to look like?

For professionals

1. Tell me a bit about your work history and professional background
2. What would you consider to be your field of practice currently?
3. How do you first become involved with someone who may be coming under an order?
4. Who are the key players and what are their roles?
5. How is information shared about the person, what kind of information is shared and with whom is it shared?

6. What particular issues do care recipients face when going through the court process under IDCC&R?
7. How do you view care recipients? How do you think they are viewed by others?
8. What is your ongoing involvement once an individual becomes a care recipient?
9. What responsibilities if any do you see yourself as having in the IDCC&R process?
10. Based on what you have experienced with particular individuals what happens once an order is made?
11. Tell me about your views of residential services under this framework?
12. Tell me about your views of vocational services under this framework?
13. What other supports are available and what are your views on them?
14. In your view how are issues such as culture considered under this framework?
15. How is gender considered under this framework?
16. How does an individual come off an order?
17. What requirements would need to be met for an individual to come off early?
18. What does an individual's life generally look like once they come off orders?
19. What is your view of the outcomes that the legislation provides?

20. What impact if any do you believe that the legislation has on the ability for former care recipients to live successfully in the community?

21. Do you have any other comments you would like to add?

Appendix F – Confidentiality Agreement

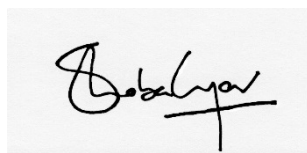
<h1>Confidentiality Agreement</h1>	 <p>AUT UNIVERSITY <small>TE WĀNANGA ARONUI O TAMAKI MAKAU RAU</small></p>
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For someone transcribing data, e.g. audio-tapes of interviews

Project Title: Experiences of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003.

Researcher: Amanda Smith

- ✓○ I understand that all the material I will be asked to transcribe is confidential.
- ✓○ I understand that the contents of the tapes or recordings can only be discussed with the researchers.
- ✓○ I will not keep any copies of the transcripts nor allow third parties access to them while the work is in progress.



Transcriber's signature:

Transcriber's name: Shoba Nayar.....

Transcriber's Contact Details (if appropriate):

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021 520 465

Date: 2/06/2010

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on 25/05/10, Reference number: NTX/10/04/029*

Note: The Transcriber should retain a copy of this form.